Ascension St. Vincent's
Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Denosumab (Prolia, Xgeva) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	Weight	_____ kg	Allergies	☐ NKDA	☐ List: _____

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐ Osteoporosis ☐ Cancer Treatment-Induced Bone Loss ☐ Hypercalcemia ☐ Other: _____	☐ M80.0_ _ _, M81.0, M81.8, Z87.310, Z79.52 ☐ Z79.811, Z79.818, M80.0, M81.0, M81.8, M85.9 ☐ E83.52 ☐ Other: _____	☑ J0897	☑ CPT Code: _____

Labs (prior to scheduling infusion)	Other Labs
☑ Calcium Level, 25-hydroxyvitamin D level, BMP	☐ _____ ☐ _____

Nursing Orders	Premedications (not required)	
☑ Discharge patient when stable and meets protocol criteria	☐ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
Emergency/Anaphylaxis Order	☐ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☑ Follow standard orders for management of allergies and anaphylaxis reactions	☐ Dexamethasone 20 mg IV, once	☐ Other: _____
	☐ Ondansetron 4 mg IV, once	☐ Other: _____

Medication Orders

	Medication	Route	Dose	Frequency	Select Treatment Type
☑	Prolia	SQ	☐ 60 mg ☐ 120 mg ☐ 180 mg	Once	☐ Maintenance: Every 6 months for ____ dose(s) ☐ Other: _____

Order Comments:
*Pharmacy may adjust dose +/- 10% of calculated dose per Pharmacy and Therapeutics Committee approved protocol.

Infusion Center Staff Please fax infusion records or discharge summary to: **Fax Number _____**

Provider Signature		Date	
Provider Printed Name			