



Thank you for selecting our infusion services team to care for your patient. If you are not a PeaceHealth provider, all information listed below is required before we can process orders and schedule your patient for treatment.

Part A- Patient scheduling and contact information:

Patient Name (Last, First): _____ Date of Birth: _____

Patient Contact Information and Phone Number (s): _____

Ordering Provider Name (Print): _____

Provider Clinic or Service Address: _____

Clinic or Service Phone Number: _____ Clinic or Service Fax Number: _____

Diagnosis (include ICD 10 codes): _____

Medication and Service Requested- list J-Code/ CPT code if known: _____

Date Service is Requested to Begin: _____ **Date Service is Expected to End:** _____

Order will expire 1 year from date of provider signature unless "date service is expected to end" is earlier.

Part B- Insurance and Prior Authorization. Any non-PeaceHealth provider must obtain prior authorization prior to service. Attach a copy of authorization documentation received from insurance payer when submitting orders.

Insurance (Payer) Company: _____

Prior Authorization Number and Conditions: _____

Prior Authorization Expiration Date: _____

Insurance (Payer) Contact Phone Number: _____

Part C- Elements needed to guide medication therapy are included with request for service:

- All orders and instruction (please use the PeaceHealth approved ordering form) are complete and include provider signature AND printed name at the bottom of each order page. Check the boxes of ALL orders you would like to activate.
- For blood products, PeaceHealth Blood and Transfusion Consent form is signed and dated by the provider and the patient.

If information is located outside of PeaceHealth's electronic medical record system attach the following:

- A list of current medications reconciled by patient provider is available and includes a list of known allergies.
- Recent progress notes from ordering provider.
- A copy of relevant laboratory results and other appropriate supporting documentation.

IMPORTANT MESSAGE TO PROVIDERS: To reduce delays in treatment and phone calls to your office you may participate in the PHMC formulary process by signing this document. A clinical pharmacist will adjust orders according to PHMC approved policies and procedures.

I agree to utilize PHMC policies & procedures that have been reviewed by the Pharmacy & Therapeutics Committee and authorized by the Medical Executive Committee of PHMC. This agreement will be issued for the duration of active orders contained within this treatment plan.

PROVIDER SIGNATURE: _____ **DATE:** _____ **TIME:** _____

FAX completed service request and completed orders to: PHMC OP Infusion and Nursing Services 541-902-1649



Denosumab (PROLIA) Outpatient Infusion Therapy Plan

All Pre-Selected Boxed Orders Are Initiated by Default Unless Crossed Out by Practitioner. All Boxed Orders Require Practitioner Check to be Initiated.

Heading	Content
For Admission To Service	<p>Provider Instruction – Review the information below and address requirements for admission to service:</p> <ol style="list-style-type: none"> 1. Denosumab (Prolia) administration is restricted to patients who have failed bisphosphonate therapy or for continuation of therapy. <ul style="list-style-type: none"> <input type="checkbox"/> Patient has failed bisphosphonate therapy with: <ul style="list-style-type: none"> • Agent: _____ • Failed due to: _____ <input type="checkbox"/> Continuation of therapy 2. CMP is required prior to patient beginning treatment (see order below). 3. Ensure adequate calcium and vitamin D intake to prevent or treat hypocalcemia. Calcium 1000 mg/day and vitamin D ≥ 400 units/day is recommended in product labeling (Prolia). 4. Remind patient of importance of good dental hygiene and ensure patient has had a satisfactory dental exam prior to start of therapy. 5. Review FDA Risk Evaluation and Mitigation Strategies for PROLIA and provide patient with the required education.
Supportive Care	<p>Treatment of osteoporosis and/or bone loss:</p> <p><input checked="" type="checkbox"/> Denosumab (Prolia) 60 mg injection subcutaneously once every 6 months</p>
Labs	<p><input checked="" type="checkbox"/> CMP once within 14 days prior to initial treatment and every 6 months with ongoing treatment.</p> <p><input type="checkbox"/> CMP once within 14 days AFTER treatment for patients with increased risk of hypocalcemia.</p> <p><input checked="" type="checkbox"/> Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post planned treatment date.</p>
Nursing Orders	<p><input checked="" type="checkbox"/> Provide patient with the FDA approved medication guide for Prolia.</p> <p><input checked="" type="checkbox"/> Nursing communication – Instruct patient to take calcium 1000 mg daily and at least 400 IU vitamin D daily.</p> <p><input checked="" type="checkbox"/> Nursing communication – Remind patient of good dental hygiene and to avoid dental procedures other than cleaning.</p> <p><input checked="" type="checkbox"/> Nursing communication – If patient is new to therapy, must have baseline CMP (within the last 14 days). Use corrected calcium within 6 months for Prolia, no need to wait to proceed. If Calcium lab greater than 6 months, draw calcium, wait for results prior to administration of Prolia. Notify provider if calcium less than 8.5.</p>
Emergency Medications	<p>If patient has symptoms of anaphylaxis (wheezing, dyspnea, hypotension, angioedema, chest pain, or tongue swelling), discontinue infusion and initiate standard emergency response procedures.</p> <p><input checked="" type="checkbox"/> Standard Emergency Medications:</p> <p><input checked="" type="checkbox"/> DiphenhydrAMINE (Benadryl) injection 25-50 mg IM once as needed for mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (>/= 20 points in SBP), nausea, urticaria, chills, pruritic).</p>

Practitioner Signature: _____ **Date of Order:** _____ **Time:** _____

Final page of orders must include signature of the ordering practitioner, date, and time.

Patient Identification Label



**Denosumab (PROLIA)
Outpatient Infusion Therapy Plan**

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Heading	Content
	<ul style="list-style-type: none"> • Administer 50 mg IM if patient has NOT had diphenhydramine within 2 hours of reaction • Administer 25 mg IM if patient has had diphenhydramine within 2 hours of reaction, if reaction doesn't resolve in 3 minutes may repeat 25 mg IM dose for a total of 50 mg and contact provider. <p><input checked="" type="checkbox"/> Albuterol 90 mcg/actuation inhaler 2 puffs once as needed for wheezing, shortness of breath associated with infusion reaction and contact provider. Administer with a spacer if available.</p> <p><input checked="" type="checkbox"/> MethylPREDNISolone (Solu-Medrol) injection 125 mg IM once as needed for shortness of breath for continued symptoms of mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (>= 20 points in SBP), nausea, urticaria, chills, pruritic) that worsen or persist 5 minutes after administration of diphenhydramine (Benadryl) and contact provider. Do not inject into deltoid.</p> <p><input checked="" type="checkbox"/> EPINEPHrine (Adrenalin) injection 0.5 mg IM once as needed for severe drug reaction (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort plus blood pressure changes (>= 40 points in SBP), shortness of breath with wheezing and O2 Sat less than 90% and contact provider.</p>
Referral	<input checked="" type="checkbox"/> Ambulatory referral to OP Infusion Services
PHMC Outpatient Infusion Contact Information	<p>PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:</p> <p>PeaceHealth Peace Harbor Medical Center Outpatient Infusion Services Department 400 Ninth Street Florence, OR 97439 Contact Phone: 541-902-6019 and FAX 541-902-1649</p>
Authorization by Verbal or Telephone Order	Person giving verbal or telephone order: _____ Person receiving verbal or telephone order: _____ <input type="checkbox"/> Check to indicate verbal or telephone orders have been read back to confirm accuracy

Practitioner Signature: _____ **Date of Order:** _____ **Time:** _____

Final page of orders must include signature of the ordering practitioner, date, and time.