LOUIS H. MEDVED, MD
INFUSION THERAPY

Patient Name:

DOB:

Prolia® (denosumab) Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Post-menopausal osteoporosis (ICD-10)

_____ Male osteoporosis (ICD-10)

_____ Cancer treatment-induced osteoporosis (ICD-10)

_____ Other: _____ (ICD-10)

Date of last Prolia injection (if applicable): _____

Serum calcium results required. Results should be obtained no more than 14 days prior to treatment. Please choose one:

- ☐ Lab results attached. Date collected: _____
- ☐ Patient has been provided with lab order and instructions to have drawn within two weeks of scheduled injection. To prevent delays in patient care, please indicate on lab order **"CC results to Infusion Services: 614-427-2184"**

Nursing Orders

☑ Hold treatment and notify provider for:

- Hypocalcemia (or calcium level within 14 days unavailable)
- Signs or symptoms active infection
- Planned/recent invasive dental procedures
- Jaw, thigh or groin pain, or dermatologic changes since starting Prolia
- A history of severe bone, muscle or joint pain following Prolia injections
- Chance of pregnancy

Administer **Prolia 60 mg subcutaneously** in the upper arm, abdomen or upper thigh.

Observation Period:

☑ Following initial Prolia injection, observe patient for 15 minutes for hypersensitivity. Patients who have previously received and tolerated Prolia do not require observation period.

☑ If reaction occurs, initiate Hypersensitivity Reaction Management Policy/Protocol as clinically indicated.

Frequency: ☐ Repeat once in 6 months

Provider (please print): _____

Provider signature: _____ Date: _____

Revised 10/24/19. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.