ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Osteoporosis Treatments

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis:
- ❑ Osteoporosis
- ❑ Osteopenia
- ❑ Other_____

ICD -10 Code:
- ❑_____
- ❑_____
- ❑_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs. Dexa scan is recommended every 2 years.
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline labs required:
- BMP
- Serum Calcium _____ mg/dL
  Contraindicated to give denosumab, romosozumab-aqqg or bisphosphanates in patients with hypocalcemia
- Serum Creatinine _____ mg/dL
  Contraindicated to give zoledronic acid if CrCl <35 mL/min, or ibandronate if CrCl <30 mL/min
- Annual Vitamin D level (25-hyroxyvitamin D)_____ng/mL (Zoledronic Acid, Ibandronate)

Maintenance labs required:
- Serum Creatinine (q3 months for ibandronate, q6 months for denosumab and romosozumab-aqqg, q12 months for zoledronic acid)
- Serum Calcium every 6 months for denosumab, ibandronate OR romosozumab-aqqg; every 12 months for zoledronic acid
- Vitamin D level (25-dyroxyvitamin D) every 12 months (Zoledronic Acid, Ibandronate)

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Treatment Regimen:
- ❑ Denosumab (Prolia) 60 mg SQ every 6 months x 1 year
- ❑ Zoledronic Acid (Reclast) 5 mg IV infusion over at least 15 minutes x 1 dose
  - Recommended to have patient hold furosemide or torsemide morning of infusion
- ❑ Ibandronate (Boniva) 3 mg IV push over 30 seconds every 3 months x 1 year
  - Recommended to have patient hold furosemide or torsemide morning of dose
- ❑ Romosozumab-aqqg (Evenity) 210 mg (administered as 2 injections) SQ every month x 12 doses
  - Contraindicated in patient with history of stroke or myocardial infarction within the preceding year

☑ **Vital Signs:** Check vital signs prior to dose.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):
- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for futher orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expire in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order

OSTEOPOROSIS TREATMENTS

MultiCare

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