



**St. Charles Health System**

Adult Ambulatory Infusion Order  
Denosumab or biosimilar

Patient Name:  
Date of Birth:

*Patient Identification*

**ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK ( ✓ ) TO BE ACTIVE**

**Treatment Start Date:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_  
**Weight:** \_\_\_\_\_ **kg** **Height:** \_\_\_\_\_ **cm**

**REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety**

- 1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
- 2. Recent VISIT NOTE to support treatment (if not available in Epic)**
- 3. LAB RESULTS for any required prescreening (if not available in Epic)**
- 4. DIAGNOSIS CODE** \_\_\_\_\_
- 5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

**GUIDELINES FOR ORDERING**

1. Send FACE SHEET and H&P or most recent chart note.
2. All patients should be prescribed daily calcium and vitamin D supplementation
3. In patients with severe renal impairment (BSA-adj eGFR less than 30 mL/min), high risk of hypocalcemia, disturbances of mineral metabolism (e.g. hypoparathyroidism, thyroid surgery, parathyroid surgery, malabsorption syndromes, excision of small intestines) recommend clinical monitoring of calcium, magnesium and phosphorus levels within 14 days of denosumab injection.
4. Risk verses benefit regarding osteonecrosis of the jaw and hip fracture must be discussed prior to treatment.
5. A complete metabolic panel is recommended, and a calcium level must be obtained within 60 days prior to starting treatment
6. The corrected calcium level should be greater than or equal to 8.6 mg/dL (or ionized calcium greater than or equal to 1.1 mmol/L).
7. Pregnancy must be ruled out prior to administration. Perform pregnancy testing in all females of reproductive potential prior to administration of denosumab.
8. Must complete and check the following box:  
  - Provider confirms that the patient has had a recent oral or dental evaluation and/or has no contraindications to therapy related to dental issues prior to initiating therapy.

**LABS:**

- Complete metabolic panel, routine, ONCE, every visit

**NURSING ORDERS:**

1. Review previous creatinine clearance, serum calcium and albumin.
2. TREATMENT PARAMETER – Hold and contact provider for corrected calcium less than 8.6 mg/dL (or ionized calcium less than or equal to 1.1 mmol/L).
3. TREATMENT PARAMETER – Hold and contact provider for vitamin D level under 27 ng/mL.



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- 4. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.
- 5. Vital Signs: Initial and PRN

**MEDICATIONS:**

**Biosimilar selection (must check one) – applies to all orders below, products listed in preference to St. Charles**

- denosumab-bnht (Conexence) (St. Charles preferred brand)
- denosumab-bmwo (Stoboclo)
- denosumab-bbdz (Jubbonti)
- denosumab (Prolia)
- \_\_\_\_\_

At SCHS, if insurance requires a different biosimilar agent, pharmacy will update the order per CDTM.

- Only check this box if it is NOT okay to substitute for insurance. Dispense as written (DAW).

- Administer denosumab 60 mg subcutaneously once every 180 days for 2 doses. Administer injection into upper arm, upper thigh, or abdomen.
- Administer denosumab 60 mg subcutaneously **ONCE**. Administer injection into upper arm, upper thigh, or abdomen.

**INFUSION MONITORING/REACTION:**

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebuler, AS NEEDED x1 dose for hypersensitivity reaction

- Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

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Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center  
2500 NE Neff Road, Bend, OR 97701  
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

**ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION**

Signature: \_\_\_\_\_ License #: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Plan will expire 1 year after signature date at which time a new order will need to be placed**