Corewell Health™

Reset Form

PREFERRED CLINIC: --Select--

Physician's Orders – Osteoporosis Denosumab 60 mg Subcutaneous Every 6 Months

PATIENT INFORMATION

Name: Date of Birth: Phone:

Address: Height: (cm) Weight: (kg)

Anticipated Infusion Date: Allergies:

CLINICAL INFORMATION

Common ICD-10 codes: ☐ M81.0 Age-related osteoporosis without current pathological fracture ☐ M81.8 Other osteoporosis without current pathological fracture

Other (Code & description required) ICD-10 Code: ICD-10 Description:

LABS

	Frequency/Duration		Frequency/Duration
☐ CMP	_____	☐ Magnesium, Blood level	_____
☐ CBC w/Differential	_____	☐ Phosphorus, Blood level	_____
☐ Beta hCG Quantitative	_____		

MEDICATION – DENOSUMAB SUBCUTANEOUS

☐ **Preferred denosumab biosimilar** - Corewell Health selects product (Guided by Corewell Health and patient's insurance formulary)

☐ **Dispense as written (DAW)** _____

Dose	Frequency		Duration	
☐ 60 mg	☐ Every 181 days	☐ Every _____ days	☐ 1 year	☐ Until date: _____

SUPPLEMENTAL ORDERS

☒ Renal function (serum creatinine) and serum calcium must be resulted within 3 months of administration.

☒ Ensure adequate calcium and vitamin D intake to prevent or treat hypocalcemia. Monitor serum calcium levels regularly throughout treatment due to risk for hypocalcemia.

☒ MEDICATION GUIDE: An FDA-approved patient medication guide, which is available with the product information and should be dispensed with this medication. Https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/125320s181lbl.pdf#page=27

☒ Rule based evaluation for monthly pregnancy test before chemotherapy cycles. Pregnancy test required: Female, aged 12 to 60 years, Uterus is still intact.

☒ May proceed with treatment if patient does not report any symptoms of jaw or dental pain.

☒ May proceed with treatment if serum calcium greater than 8.6 mg/dL.

☒ Contact provider if patient has upcoming dental procedure for further instructions.

RECOMMENDED DOCUMENTATION: ☐ Insurance Card / Information ☐ Progress Notes & Labs Supporting Diagnosis

PROVIDER INFORMATION

Referring Physician: Phone: Fax:

Address: City: State: Zip Code:

Direct line for urgent questions about patient: Weekend on call phone (if applicable):

_____ **Provider Signature**

_____ **Date**

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