

Physician's Orders **DENOSUMAB (PROLIA) - ADULT,** **OUTPATIENT, COREWELL HEALTH INFUSION CENTER**

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Corewell Health Site of Service (select one):

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Blodgett Hospital
1840 Wealthy St. NE
Grand Rapids, MI 49506
Phone: 616.391.0351
Fax: 616.391.8969 | <input type="checkbox"/> Gerber Hospital
230 West Oak St.
Fremont, MI 49412
Phone: 231.924.1305
Fax: 231.924.1798 | <input type="checkbox"/> Greenville Hospital
615 S. Bower St.
Greenville, MI 48838
Phone: 616.225.9330
Fax: 616.754.4043 | <input type="checkbox"/> Helen DeVos Children's Hospital
100 Michigan St. NE
Grand Rapids, MI 49503
Phone: 616.267.1925
Fax: 616.267.1005 |
| <input type="checkbox"/> Lemmen Holton Cancer Pavilion 145 Michigan St. NE
Grand Rapids, MI 49503
Phone: 616.486.6099
Fax: 616.486.6415 | <input type="checkbox"/> Ludington Hospital
1 Atkinson Dr.
Ludington, MI 49431
Phone: 231.845.5085
Fax: 231.845.5025 | <input type="checkbox"/> Neuro Infusion ICCB
2750 E Beltline Ave NE
Grand Rapids, MI 49525
Phone: 616.391.0351
Fax: 616.391.8669 | <input type="checkbox"/> Pennock Hospital
1009 W. Green St.
Hastings, MI 49058
Phone: 269.798.6762
Fax: 269.798.6763 |
| <input type="checkbox"/> Reed City Hospital
4499 220 th Ave.
Reed City, MI 49677
Phone: 231.832.7105
Fax: 231.832.0915 | <input type="checkbox"/> Zeeland Hospital
8333 Felch St.
Zeeland, MI 49464
Phone: 616.748.3640
Fax: 616.748.3690 | | |

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Brownstown Infusion Clinic
19725 Allen Rd. Suite 101
Brownstown Twp, MI 48183
Phone: 734.479.2371
Fax: 734.479.2451 | <input type="checkbox"/> Dearborn Hospital
18101 Oakwood Blvd.
Dearborn, MI 48124
Phone: 313.593.5913
Fax: 313.593.8551 | <input type="checkbox"/> Farmington Hills Hospital Botsford
28050 Grand River Ave.
Farmington Hills, MI 48336
Phone: 947.521.8174
Fax: 248.471.8217 | <input type="checkbox"/> Grosse Pointe Infusion Clinic
21400 E 11 Mile Rd.
Saint Clair Shores, MI 48081
Phone: 586.498.4498
Fax: 586.498.4497 |
| <input type="checkbox"/> Lenox Infusion Clinic
36555 6 Mile Rd.
Lenox, MI 48048
Phone: 947.523.4060
Fax: 947.523.4061 | <input type="checkbox"/> Livonia Infusion Clinic
39000 7 Mile Rd. Suite 1000
Livonia, MI 48152
Phone: 947.523.4360
Fax: 734.542.3356 | <input type="checkbox"/> Royal Oak
3601 W 13 Mile Rd.
Royal Oak, MI 48073
Phone: 248.898.1000
Fax: 248.551.3168 | |
| <input type="checkbox"/> Troy Hospital
44344 Dequindre Rd. Suite 230
Sterling Heights, MI 48314
Phone: 248.964.3080
Fax: 248.964.2409 | <input type="checkbox"/> Wayne Hospital
33155 Annapolis St.
Wayne, MI 48184
Phone: 734.467.2556
Fax: 734.467.2505 | | |

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|--|--|---|
| <input type="checkbox"/> Marie Yeager Cancer Center
3900 Hollywood Rd.
Saint Joseph, MI 49085
Phone: 269.556.7180
Fax: 269.556.7185 | <input type="checkbox"/> Niles Infusion
42 N St. Joseph Ave Ste 303
Niles, MI 49120
Phone: 269.684.6140
Fax: 269.683.8744 | <input type="checkbox"/> Watervliet Hospital
400 Medical Park Dr.
Watervliet, MI 49098
Phone: 269.463.2310
Fax: 269.463.0012 |
|--|--|---|

PATIENT INFORMATION:

Name: First _____ Middle _____ Last _____
Date of birth _____ Phone (____) _____
Address _____
City _____ State _____ Zip code _____

REFERRAL: Infusion Therapy

Referring Physician (print) _____

Office: Phone (____) _____ Fax (____) _____

Direct line for urgent questions about patient (____) _____

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NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

Patient Name _____

DOB _____

MRN _____

Physician _____

CSN _____

DENOSUMAB (PROLIA) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER (CONTINUED)

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Infusions

Anticipated Infusion Date: _____ ICD-10 Code with Description: _____

Height _____ (cm) Weight _____ (kg) Allergies _____

Labs to be collected

☒ Comprehensive Metabolic Panel (CMP)

☐ Once

☒ Every 181 days

☐ _____

☒ Complete Blood Count (CBC) w/Differential

☐ Once

☒ Every 181 days

☐ _____

☒ Magnesium, Blood Level

☐ Once

☒ Every 181 days

☐ _____

☒ Phosphorus, Blood Level

☐ Once

☒ Every 181 days

☐ _____

☐ Additional lab order(s) _____

☐ Once

☐ Every 181 days

☐ _____

Rule based evaluation for monthly pregnancy test before chemotherapy cycles

☒ ONC PROVIDER REMINDER 28

This patient does not qualify for pregnancy test based on the following criteria:

- Female, aged 12 to 60 years
- Uterus is still intact

If you disagree, consider adding a pregnancy test monthly prior to chemotherapy.

☐ Beta Human Chorionic Gonadotropin (hCG) Quantitative

Treatment

Frequency:

☐ Every 181 days

☐ _____

Duration:

☐ 1 year

☐ # of treatments _____

☐ Until date: _____

☒ Denosumab (PROLIA) injection 60 mg, Subcutaneous

Patient Name

DOB

MRN

Physician

CSN

DENOSUMAB (PROLIA) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER (CONTINUED)

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Supplemental Orders

The following orders will be applied to the patient's plan unless otherwise indicated

Appointment Requests

☒ Infusion Appointment Request

Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after injection and possible labs

Safety Parameters and Special Instructions

☒ ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 1

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

☒ ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 5

DENOSUMAB (PROLIA):

Ensure adequate calcium and vitamin D intake to prevent or treat 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

Monitor serum calcium levels regularly throughout treatment due to risk for hypocalcemia.

Treatment Parameters

☒ ONC MONITORING AND HOLD PARAMETERS 3

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

☒ ONC MONITORING AND HOLD PARAMETERS 3

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

☒ ONC MONITORING AND HOLD PARAMETERS 3

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

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED: TIME	DATE	VALIDATED: TIME	DATE	ORDERED: TIME	DATE	Pager #
			R.N. Sign		Physician Print	Physician Sign

EPIC VERSION DATE: 12/8/23