Holland Hospital

AMBULATORY TREATMENT UNIT

Denosumab (Prolia) Osteoporosis Order Set

☐ = Optional Order ● = Routine Order (Cross out and initial **BULLETED ORDERS** that do not apply)

Phone (616) 394-3547
Fax (616) 394-2139

ORDERS

Date: _____ **Time:** _____

Patient Name: _____ **Date of Birth:** _____ **Weight:** _____ (kg)

Allergies: _____

Exclusion Criteria: hypersensitivity (systemic) to denosumab or any component of the formulation; preexisting hypocalcemia; pregnancy.

Diagnosis Code: (ICD-10) _____

- ☐ **Diagnosis:** Treatment of postmenopausal women with osteoporosis at high risk for fracture.
- ☐ Treatment to increase bone mass in men with osteoporosis at high risk for fracture.
- ☐ Treatment of glucocorticoid-induced osteoporosis in men and women at high risk for fracture.
- ☐ Treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer.
- ☐ Treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer.

☑ Administer denosumab (Prolia) 60mg subcutaneously times one.

PRE-INJECTION / LAB ORDERS
DIAGNOSTICS & TESTS

Results
(Within 45 days of administering Prolia)

DATE	SERUM CREATININE	DATE	SERUM CALCIUM *(NORMAL 8.6 – 10.6 MG/DL)*	CALCIUM WDL? **
				❑ Yes

**Hold medication if serum calcium level is not within normal range.

NURSING MONITORING PARAMETERS

- Administer denosumab (Prolia) by subcutaneous technique in the upper lateral arm, abdomen, or lateral thigh. See package insert for proper subcutaneous administration and site selection.
- Do not administer denosumab (Prolia) intraarterially, intra-muscularly or intravenously.
- Counsel the patients to take calcium 1200mg daily with at least 800 units of vitamin D daily

☑ **By signing this order, the Medication Guide and Patient Counseling Chart per FDA REMS Requirement for Prolia has been reviewed with the patient and handed to her/him including the serious risks of Prolia and symptoms of each risk.**

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____