



(denosumab)

# PROLIA Infusion Orders

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender:  M  F

Phone \_\_\_\_\_

**DIAGNOSIS:** *Please provide IDC-10 Code*

- \_\_\_\_\_ Age-related osteoporosis **without** current pathological fracture
- \_\_\_\_\_ Age-related osteoporosis **with** current pathological fracture
- \_\_\_\_\_ Cancer treatment-induced bone loss due to hormone ablation therapy (CTIBL-HAT)
- \_\_\_\_\_ (other)

**PRE-MEDICATION:**

- Tylenol 1000mg PO
- Cetirizine 10mg PO
- Diphenhydramine 25mg PO
- \_\_\_\_\_ (other)

**PROLIA ORDERS:**

**DOSAGE**

- 60mg SQ every six months

**PATIENT WEIGHT**

\_\_\_\_\_ Last Prolia injection date (if applicable)

\_\_\_\_\_ LBS  
\_\_\_\_\_ KG

- Emergency Orders and Treatment per Novello Infusion Anaphylaxis Policy**

**NOTES:**

**Nursing Orders**

- Assess patient prior to each infusion
- Provide patient/caregiver education related to disease process, therapy, infection control, drug use, side effects and precautions, emergency plan
- Weigh patient every visit and record
- Monitor vital signs initially and throughout infusion per manufacturer recommendations
- Administer injection as ordered

**ORDERING PROVIDER:**

Signature \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date \_\_\_\_\_

Practice \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

\*\*\*PLEASE FAX COMPLETED ORDER TO NOVELLO INFUSION 231-600-7058\*\*\*