BioPlus® Infusion

**Fax your completed order to 877-734-1157**

Patient Name: _____ DOB: ___/___/_____

Date of Last Infusion: ___/___/_____ Height _____ Weight _____

Infusion Location: (state and site) _____

# Prolia® (denosumab) Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Post-menopausal osteoporosis (ICD-10)

_____ Male osteoporosis (ICD-10)

_____ Cancer treatment-induced osteoporosis (ICD-10)

_____ Other: _____ (ICD-10)

Date of last Prolia injection (if applicable): _____

## Nursing Orders

-Hold treatment and notify provider for:

- Signs or symptoms active infection or chance of pregnancy
- Planned/recent invasive dental procedures
- Jaw, thigh or groin pain, or dermatologic changes since starting Prolia
- A history of severe bone, muscle or joint pain following Prolia injections
- Lab levels showing hypocalcemia
- **Patient must be on Calcium and vitamin D orally unless contraindicated**

Labs (Required):

☐ Obtain serum calcium level 7-14 days prior to infusion. (must be completed at external lab and faxed to infusion dept at _____)

☐ Prolia 60 mg subcutaneously in the upper arm, abdomen or upper thigh.

☐ Repeat once in 6 months

## Observation Period:

-Following initial Prolia injection, observe patient for 15 minutes for hypersensitivity. Patients who have previously received and tolerated Prolia do not require observation period

-If reaction occurs, initiate Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Additional Orders:

_____

Provider Name (print): _____ Date: _____

Provider Signature: _____ Time: _____

Reviewed 4/24/23. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.