



# BISPHOSPHONATE ORDERS

## ZOLEDRONIC ACID (RECLAST)

### DENOSUMAB (Prolia/Stoboclo/Jubbonti)

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#### PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

#### REFERRAL STATUS

<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency Change	<input type="checkbox"/> Order Renewal
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#### DIAGNOSIS AND ICD 10 CODE

<input type="checkbox"/> Age related Osteoporosis <b>with</b> current pathological fracture	ICD10 Code: M80.0
<input type="checkbox"/> Age related Osteoporosis <b>without</b> current pathological fracture	ICD10 Code: M81.0
<input type="checkbox"/> Osteopenia	ICD10 Code: M85.80
<input type="checkbox"/> Other Diagnosis:	ICD10 Code:

#### REQUIRED DOCUMENTATION

<input type="checkbox"/> This order form signed by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Serum creatinine and serum calcium level <input type="checkbox"/> Documentation of oral hygiene	<input type="checkbox"/> Clinical/ Progress notes, including H&P <input type="checkbox"/> Labs and tests supporting primary diagnosis <input type="checkbox"/> DEXA scan results and/or FRAX score
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#### Tried AND failed therapies, including duration of treatment (specifically bisphosphonates):

<input type="checkbox"/> Actonel (Risedronate) <input type="checkbox"/> Forteo (Teriparatide) <input type="checkbox"/> Reclast (Zoledronic acid) <input type="checkbox"/> Progesterone injections/ supplements <input type="checkbox"/> Any calcium supplements or Tums	<input type="checkbox"/> Boniva (Ibandronate) <input type="checkbox"/> Fosamax (Alendronate) <input type="checkbox"/> Estrogen injections/ supplements <input type="checkbox"/> Prednisone or other steroids <input type="checkbox"/> Any generic medicine for osteoporosis	<input type="checkbox"/> Evista (Raloxifene) <input type="checkbox"/> Miacalcin (Calcitonin) <input type="checkbox"/> Testosterone injections/ supplements <input type="checkbox"/> Synthroid or any thyroid medicine <input type="checkbox"/> Other: _____
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<input type="checkbox"/> Patient has previously received Prolia or Denosumab biosimilar.
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#### MEDICATION ORDERS

Dosing: <input type="checkbox"/> <b>Stoboclo/Jubbonti/Prolia</b> 60mg SQ every 6 months x 2 doses	Dosing: <input type="checkbox"/> <b>Reclast</b> 5mg IV once yearly x 1 dose <b>OR</b> Dosing: <input type="checkbox"/> <b>Reclast</b> 5mg IV once every 2 years
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Treatment Labs:

- ✓ Pregnancy test within 72 hours prior to initiation of therapy for female patient under 55 years of age and no history of surgical hysterectomy
- ✓ Vitamin D within 72 hours of initiation of first dose of therapy
- ✓ CMP, Magnesium and Phosphorus within 72 hours of each dose

- New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.
- Please note for patients receiving treatment at the Montgomery Cancer Center: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.
- Please note for patient receiving treatment at Baptist East Outpatient Infusion: if an infusion reaction occurs, the Baptist East staff will follow the PRN hypersensitivity standing orders and will contact the referring provider in the event of an emergency. For life threatening anaphylaxis, Baptist East staff will follow rapid response policy or 911 facility policy.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_



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All order sets will include a statement to activate these PRN hypersensitivity standing orders when necessary.

REACTION SYMPTOMS		DRUG	DOSE	ROUTE
Fever, chills and or rigors	✓	Acetaminophen (Tylenol)	1000mg	PO
Itching, facial flushing, hives, rash	✓	Diphenhydramine (Benadryl)	50mg	IVP
	✓	Famotidine (Pepcid)	20mg	IVP
	✓	Methylprednisolone (Solu-Medrol)	125mg	IVP
Hypotension, wheezing, shortness of breath, facial/lip/tongue swelling	✓	Normal Saline	150ml/hr	IV
	✓	Diphenhydramine (Benadryl)	50mg	IVP
	✓	Methylprednisolone (Solu-Medrol)	125ng	IVP
	✓	Hydrocortisone (Solu-Cortef)	50mg	IVP
	✓	Epinephrine Pen	0.3mg	IM
Nausea/Vomiting	✓	Granisetron (Kytril)	1mg	IVP

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Physician Signature:	Date:		

For questions, please contact  
Baptist Outpatient Infusion Services @ (334) 747-7401

Fax completed form and all documentation to  
Baptist Outpatient Infusion Services @ (334) 747-7403