



Conveniently Located in East Syracuse, Onondaga Hill & Auburn

Main Office Phone 315-472-7504

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**Xgeva (denosumab) Non-Oncology Treatment Order Set**

1. Patient Name: \_\_\_\_\_

2. DOB: \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs): \_\_\_\_\_

**3. Diagnosis:**

- M81.0 Age-related osteoporosis without current fracture
- Other ICD-10 Code: \_\_\_\_\_ Diagnosis description: \_\_\_\_\_

**4. Pre-medications:**

- Other Pre-medication: \_\_\_\_\_
- No Pre-medications indicated

**5. Drug Order:**

**Xgeva (denosumab)** *Ok to substitute with generic/biosimilar*

Dose/ Frequency:

- 120mg every 4 weeks** (SQ injections to upper arm, upper thigh or abdomen)
- Other: \_\_\_\_\_

Dental Clearance:

- Ok to proceed without dental clearance
- Ok to proceed, dental clearance obtained, Date: \_\_\_\_\_ (copy of clearance attached)
- New to Therapy
- Continuing therapy: Last Dose Received \_\_\_\_\_ Next Dose Due \_\_\_\_\_

- Is the patient on Calcium & Vitamin D replacement?  Yes  No

*HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral*

**6. Infusion Lab Requirements:**

- CMP within 30 days of injection
- Other: \_\_\_\_\_
- No lab monitoring indicated

*HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.*

*The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.*

**7. Required Baseline Lab/Testing have been completed:**

- CMP, date: \_\_\_\_\_  DEXA Scan, date: \_\_\_\_\_  Other: \_\_\_\_\_  None

**8. Patient Assistance & REMS Program Enrollment**

- Yes, patient has been enrolled in \_\_\_\_\_ program. (Provide Copy Enrollment Forms)
- No, patient has not been enrolled in any programs.

7. Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(This drug administration order form is valid for 12 months)*

**Dental Clearance for Drug Administration**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**Prescribing MD:** \_\_\_\_\_ **Prescribing MD Phone Number:** \_\_\_\_\_

The above mentioned patient requires therapy with the following medication, under my supervision:

\_\_\_\_ Zometa

\_\_\_\_ Xgeva

\_\_\_\_ Aredia

\_\_\_\_ Reclast

\_\_\_\_ Prolia

\_\_\_\_ Boniva

\_\_\_\_ Evenity

Please evaluate the patient for clearance or any other recommendations following your exam.  
The patient may need follow up dental/jaw exams every six months.

Please fax this form back, with your comments, to my office at (fax) \_\_\_\_\_.

Dental Clearance APPROVED

Dental Clearance DENIED.

See Comments and Recommendation Below:

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Treating Dentist: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_

Date: \_\_\_\_\_