Denosumab (Xgeva)

Provider Order Form rev. 10/30/2023

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Post-menopausal osteoporosis: Bone metastasis, Associated with solid tumors:

Multiple myeloma: Giant cell tumor of bone:

Hypercalcemia of malignancy, Refractory to bisphosphonates:

Other: Description:

REQUIRED INFORMATION

☑ Current calcium level _____

THERAPY ADMINISTRATION *(Choose one)*

☐ **Multiple myeloma/bone metastasis from solid tumor:** Administer denosumab (Xgeva) 120mg subcutaneously every 4 weeks.

☐ **Giant cell tumor of bone/hypercalcemia of malignancy:** Administer denosumab (Xgeva) 120mg sub-q every 4 weeks with additional doses on day 8 and day 15 of the first month of treatment.

☐ **Hypercalcemia of Malignancy:** Administer denosumab (Xgeva) 120mg subcutaneously every 4 weeks with additional 120mg subcutaneously doses at Day 8 and 15 of the first month of therapy.

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Other: _____

LABORATORY ORDERS

☑ Obtain serum creatinine and calcium level withing 14 days prior to each infusion

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Hypercalcemia or hypocalcemia
- Patient is also on Prolia.
- Jaw mouth or tooth pain following treatments/Thigh, hip or groin pain/fractures of the femur or vertebra
- Suspected pregnancy
- any invasive dental work

☑ Injection should be given in the upper arm, upper thigh, or abdomen.

☑ Continue with calcium and vitamin D supplements as instructed by provider.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with biphosphates, Reclast, Prolia, Evenity. History of GERD, fractures, T score

Required Labs: Calcium and Vitamin D levels, Renal function

Provider Name *(print)* **Provider Signature** **Date**

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.