ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER	
ALLERGIES/REACTIONS (REQUIRED):	Yakima Outpatient Infusion Care 808 N 39th Ave Yakima WA 98902 Phone: 509-575-1174 Fax: 509-577-5021
ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.
CODE STATUS	Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

OSTEOPOROSIS TREATMENTS

Patient Name:_____ Requested Start Date: _____/_____/_____

Date of Birth:_____/_____/_____ Patient Weight: _____ kg Patient Height: _____

Patient Phone Number: (_____)_____-_____

***DIAGNOSIS & ICD-10 CODE*:** ❑ Osteoporosis (ICD-10: _____)
❑ Osteopenia (ICD-10: _____) *(in patients with breast or prostate cancer on aromatase inhibitor or androgen deprivation therapy)*
❑ Other_____ (ICD-10: _____)

***REQUIRED*:** H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

ADDITIONAL REQUIRED ATTACHMENTS & LABS:

- Bone density (DXA) study performed within the last 2-year (24-month) period
- Most recent lab work (within last 3 months) to support calcium level (hypocalcemia must be corrected prior to treatment) and serum creatinine
- Documentation of inadequate response or intolerance to oral bisphosphonates/medical necessity

ACCESS: *Access and maintain IV site or Port-A-Cath in accordance with the appropriate MYMH OIC P&Ps*

TREATMENT REGIMEN: *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)*

- ❑ Zoledronic acid 5 mg IV infusion over at least 15 minutes x 1 dose
  - Contraindicated if CrCl < 35 mL/min
- ❑ Ibandronate 3 mg IV push over 30 seconds every 3 months x 1 year (4 total doses)
  - Contraindicated if CrCl < 30 mL/min
- ❑ Denosumab 60 mg Sub-Q injection every 6 months x 1 year (2 total doses)
- ❑ Romosozumab-aqqg 210 mg Sub-Q injection every month x 1 year (12 total doses)
  - Contraindicated in patients with history of stroke or myocardial infarction within the preceding year

MONITORING: Initial administration: vital signs at baseline, at completion of administration, and before discharge
Subsequent administration: vital signs at baseline and at completion of administration

***SUPPORTIVE CARE*:** Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

***DISCHARGE*:** 30 minutes after infusion or injection is complete when vital signs are stable and hypersensitivity symptoms are absent. Waiting period can be waived by patient on subsequent infusions or injections.

Provider Signature: _____ Date: _____

Print name: _____ Phone # _____ Fax # _____

❑ NEW REFERRAL ❑ UPDATED REFERRAL ****Expires 12 months from written date****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

OSTEOPOROSIS TREATMENTS

MultiCare

Yakima Memorial Hospital