MIC METRO INFUSION CENTER

Denosumab (Xgeva)

Name: _____
DOB: _____
Diagnosis/Code: _____/_____

Dose calculation:
Flat dose, not a weight-based medication

Laboratory or Other Tests Related to Chemotherapy: **Provider to select preference below**
☐ STAT calcium, creatinine and phosphorus levels prior to first dose and then as indicated throughout therapy
☐ STAT CMP and phosphorus prior to every dose; check calcium, phosphorous and creatinine levels prior to administering each dose

Dosing Guidelines/ Parameters: **Provider to check box below if phosphorus monitoring is required**
- Creatinine clearance should be greater than 30 mL/minute before dosing- if lower than this, the risk for hypocalcemia is higher
- Calcium level should be greater than 8 mg/dL (make sure is corrected)

☐ Check phosphorus level prior to each treatment and call MD/NP for level less than 2.3 mg/dL

Hydration Orders: Not Required

Premedication and Antiemetic Orders: Not Required

Medication Orders:

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
☐Denosumab (Xgeva) post weekly x 3 for giant cell tumor of bone OR for prevention of SRE	120 mg	SQ	Every 4 weeks
☐Denosumab (Xgeva) For giant cell tumor of the bone)	120mg	SQ	Weekly x 3 weeks Then every 4 weeks

Day 1 = _____ then every week (+/- 2 days)

This order is good for 1 year from the date ordered

Other:
Verify patient is taking oral Vitamin-D and Calcium supplements
- Monitor for and instruct patient to report symptoms of Osteonecrosis of the Jaw (pain, numbness, swelling of or drainage from the jaw, mouth or teeth).

Call referring provider for:
- Sore in the mouth that could be osteonecrosis of the jaw
- SxS of low calcium or phosphorus
- Unusual or worsening pain in the upper thighs or back as there have been occasion of atypical femoral and vertebral fractures

Other reasons to call:

Contact us with questions at: BioNurses@MetroInfusionCenter.com or call (877) 448-3627 Fax completed form and all documentation to (866) 507-1164 All information contained in this form is strictly confidential and will become part of the patient's medical record.

DATE	Referring Provider:_____ _____ Telephone#_____
	SIGNATURE REQUIRED PRINTED NAME REQUIRED