MIC METRO INFUSION CENTER

Denosumab

☐ Xgeva ☐ denosumab-bbdz (Wyost)

☐ denosumab-bbdz (Jubbonti)

Name: _____

DOB: _____

Diagnosis/Code: _____ / _____

Cancer Stage: _____

Dose calculation:

Flat dose, not a weight based medication

Required Documentation:

☐ Recent serum Calcium result.

*Referring physician is responsible for monitoring and reviewing serum Calcium level prior to dose of Denosumab.

☐ Oral health clearance.

Dosing Guidelines/Parameters: ***Provider must select hold parameters that will trigger a call from the Infusion Staff***

Hydration Orders:

☐ Not required

Other:

Premedication and Antiemetic Orders:

☐ Not required

Treatment Orders:

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
☐ Denosumab/biosimilar	120mg	SQ	Every _____weeks
☐ Denosumab/Biosimilar	120mg	SQ	Every _____months

Date of intended first treatment at Metro Infusion Center: _____

Subsequent treatment may be given +/- 2 days or as otherwise specified:

This order is good for 1 year from the date ordered

Other:

Call referring provider for:

Date:

Referring Provider: _____ _____ Phone# _____

SIGNATURE REQUIRED PRINTED NAME REQUIRED

Office Contact name/number: _____

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email: MICreferral@metroinfusioncenter.com or fax to (866)507-1164

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