Columbus Community Hospital
Columbus, Nebraska
DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here ☐

PHYSICIANS ORDERS (including Medications)

Pamidronate (AREDIA) Infusion **(8/2024)**

Diagnosis Code: ____

Treatment Start Date: _________________ Patient to follow up with provider on date: ________________________

This plan will expire after 365 days at which time a new order will need to be placed

GUIDELINES FOR ORDERING

1. Send **FACE SHEET** and **H&P or most recent chart note.**
2. In the absence of hypercalcemia, all patients with the following diagnoses should be prescribed daily calcium and vitamin D supplementation:
   - Lytic bone metastases
   - Multiple Myeloma
   - Paget's disease
3. **Must complete and check the following box:**
   ☐ Provider confirms that the patient has had a recent oral or dental evaluation and/or has no contraindications to therapy related to dental issues prior to initiating therapy.

LABS:

☑CMP, Routine, ONCE, Prior to every visit (no more than one weekly).
☐ Magnesium (plasma), Routine, ONCE, every ______ (visit)(days)(weeks)(months) – Circle One
☐ Phosphorus (plasma), Routine, ONCE, every ______ (visit)(days)(weeks)(months) – Circle One
☐ Bone Specific Alk Phos (serum), Routine, ONCE, every ______ (visit)(days)(weeks)(months) – Circle One
☐ Labs already drawn. Date: _________

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. TREATMENT PARAMETERS
   a. Hold and notify provider for Serum Calcium less than 8.6 mg/dL.
   b. If patient does not have multiple myeloma, Hold and notify provider for serum creatinine 3 mg/dL or greater, or estimated creatinine clearance 30 mL/min or less
3. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.

MEDICATIONS:

1. **Paget's disease**
   ☐ Pamidronate (AREDIA) 30 mg in sodium chloride 0.9% 500 mL, intravenous, ONCE, over 4 hours
   Interval:
   - Daily x 3 consecutive days for a total of 90 mg

(cont.)

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2. **Hypercalcemia of malignancy**
   - ☐ Pamidronate (AREDIA) ______mg in sodium chloride 0.9% 1000 mL, intravenous, ONCE, over 2 hours

   Interval: (must check one)
   - ☐ Once
   - ☐ Repeat once in 7 days
   - ☐ Repeat every ______ weeks, at least 7 days apart
3. **Osteolytic bone metastases of breast cancer**
   - ☐ Pamidronate (AREDIA) _______ mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 2 hours

   Interval: (must check one)
   - ☐ Once
   - ☐ Repeat every week, at least 3 weeks apart. Usual intervals are 4, 8, or 12 weeks
4. **Osteolytic bone lesions of multiple myeloma**
   - ☐ Pamidronate (AREDIA) ______ mg in sodium chloride 0.9% 500 mL, intravenous, ONCE, over 2 hours

   Interval: (must check one)
   - ☐ Once
   - ☐ Repeat every________ weeks, at least 3 weeks apart. Usual intervals are 4, 8, or 12 weeks

PROVIDER TO PHARMACIST COMMUNICATION:
For multiple myeloma only – Pharmacist to adjust infusion rate for renal insufficiency. Doses will be infused over 4-6 hours for serum creatinine 3 mg/dL or greater, or estimated creatinine clearance 30 mL/min or less.

HYPERSENSITIVITY:
1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop **STOP THE INFUSION**.
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
5. Continue to assess as grade of severity may progress.
6. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:
1. **Acetaminophen**, **975 mg**, PO, x 1 dose, AS NEEDED for hypersensitivity or infusion reaction.
2. **DiphenhydrAMINE inj, 50 mg**, IV, AS NEEDED for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
3. **Hydrocortisone Sodium Succinate, 100 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
4. **Famotidine, 20 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
5. **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
6. **0.9% Normal Saline, 1000 mL**, IV, 150mL/hr, AS NEEDED for hypersensitivity or infusion reaction.
7. **EPINEPHrine HCl (1mg/1mL), 0.3 mg**, IM injection, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.

(cont.)

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My NPI number is _____________________________ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: ________________________________ **Date/Time:** ___________________

Printed Name: ___________________ **Phone:** _____________________**Fax:** _________________