US infusions
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DENOSUMAB ORDER FOR OSTEOPOROSIS

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION:

☐ M80.0 – Age-related osteoporosis w/current fracture

☐ M80.8 – Drug-induced osteoporosis with current fracture

☐ M81.0 – Age-related osteoporosis w/o current pathological fracture

☐ Z79.5 – Long-term use of steroids

☐ Z79.890 – Postmenopausal hormone replacement

☐ Other diagnoses: _____

PRESCRIPTION:

Denosumab (60 mg): Every 6 months ☐ No brand preference

☐ Preferred brand: ☐ Prolia ☐ Conexxance ☐ Jubbonti ☐ Stoboclo

(While best efforts will be made to obtain the selected brand, insurance coverage and formulary requirements may require substitution and will govern the final product dispensed.)

☐ New to Therapy ☐ Continuation of Therapy

THERAPIES TRIED AND FAILED:

Bisphosphonates for osteoporosis with start and end dates and reasons for discontinuation (intolerance, contraindications, fractures, impaired kidney function):

_____

REQUIRED ASSOCIATED DOCUMENTATION:

☐ Patient demographics ☐ Front/back of all insurance cards ☐ Current medication list

☐ Include clinical notes supporting one or more of the above diagnoses.

☐ Include Dexa scan results to support osteoporosis diagnosis: ☐ T-score of < -3.0 overall, ☐ T-score of ≤ - 2.5 in the lumbar spine, femoral neck, total proximal femur, or 1/3 radius, ☐ T-score between -1.0 and -2.5 and a fragility fracture of the proximal humerus, pelvis, or distal forearm.

☐ Include lab test results: ☐ CMP reflecting normal calcium levels and kidney function.

☐ Include all supporting diagnostic radiographic reports and images of fractures attributed to one or more of the above diagnoses.

PROVIDER INFORMATION:

By signing this form, you authorize US Infusions and its staff to handle prior authorizations, coordinate with insurance providers, and determine the patient's preferred site of care.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

FAX COMPLETED FORM TO US INFUSIONS AT 469-200-2606