OSTEOPOROSIS THERAPY ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:		ZIP:
Phone:	Email:	Height:	□ inches □ cm	Weight:	□lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:		ZIP:
NPI #:	DEA#:			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
□ **Denosumab OR denosumab biosimilar** *Preferred product TBD after benefits investigation (noted below) □ Do not substitute Give the following denosumab product: _____	□ 60mg subcutaneous injection every 6 months	□ _____ □ x 1 year
Evenity (romosozumab)	□ 210mg subcutaneous injection once monthly If osteoporosis therapy remains warranted, continued therapy with an anti-resorptive agent should be considered • Would you like for LIVbetter to transition the patient to denosumab or denosumab biosimilar after 12 doses of Evenity? □ Yes □ No	□ _____ □ x 12 doses

Other orders: _____

Lab Orders: _____ Lab frequency: _____

Required labs to be drawn by □ LIVbetter Infusions □ Referring Provider

For denosumab: additional pre-injection and post-injection labs are required for patients with GFR <30mLmin/1.73m²

*FOR LIVbetter USE ONLY

Drug/Brand Selection: _____

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

COMPREHENSIVE SUPPORT FOR OSTEOPOROSIS THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's current medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to other therapy
  - ☐Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., oral and/or IV bisphosphonate)?
    - ☐Yes ☐ No If yes, which drug(s)? _____
  - ☐Please indicate prior drug therapies: ☐ Boniva ☐ Forteo ☐ Reclast ☐ Prolia
    - ☐Actonel ☐ Evista ☐ Fosamax ☐ Other: _____
  - ☐Does the patient have a history of a minimal trauma fracture? ☐ Yes ☐ No
    If yes, location(s)? _____
  - ☐Patient is currently taking calcium/vitamin D supplementation ☐ Yes ☐ No
  - ☐Does the patient have a FRAX 10-year fracture probability of a major osteoporotic fracture at 20% or more OR a hip fracture at 3% or more? ☐ Yes ☐ No
  - ☐**Pre-treatment** t-score: _____ (Osteoporosis: -2.5 or worse, Osteopenia: -1.0 or worse)
- ☐ Include labs and/or test results to support diagnosis
- ☐ Other medical necessity: _____

REQUIRED INFORMATION

☐Calcium within 6 months (required for all therapies)

☐PTH; 25(OH) Vit D; 1,25 (OH)$_2$ Vit D (Proliapatients with$GFR<30mL/min/1.73m^2$)*

☐DEXA Scan (osteo)

☐Tried and failed therapies