LIVbetter INFUSIONS

OSTEOPOROSIS REFERRAL

PROLIA · EVENITY · RECLAST

P: 331-236-0610 | F: 331-314-8989 Fax this form with the face sheet

REFERRING PRESCRIBER

PRESCRIBER NAME	NPI #	PHONE	FAX

PRACTICE NAME	OFFICE CONTACT	EMAIL	REFERRAL DATE

PATIENT → Attaching a face sheet? Skip this box — just fill in the weight.

PATIENT NAME		DATE OF BIRTH	PHONE

WEIGHT	PRIMARY INSURANCE	POLICY #	GROUP #
_____ ☐ kg ☐ lb			

LABS renal function and calcium decide which drug the patient can have — please fill these in

CREATININE CLEARANCE or eGFR	SERUM CALCIUM	25-OH VITAMIN D	DXA (DEXA) T-SCORE + DATE

☐ **Calcium is normal, or low calcium has been corrected.** Every drug on this form requires this before the first dose.

☐ On calcium and vitamin D supplementation ☐ Dental exam done, or not needed ☐ Pregnancy ruled out

PRIOR TREATMENT → this is what the plan will ask for — a blank here is the most common reason we get denied

Bisphosphonate already tried Drug: _____ From: _____ to _____

☐ Failed after 12 months or more ☐ Could not tolerate it ☐ Contraindicated ☐ Fracture or falling bone density while on it

Denosumab already tried ☐ Not applicable Drug: _____ From: _____ to _____

☐ Failed after 12 months or more ☐ Could not tolerate it ☐ Contraindicated

Fragility fracture ☐ Hip ☐ Spine ☐ Other: _____ Date: _____ **FRAX 10-year risk:** major _____ % hip _____ %

☐ On oral glucocorticoids 3 months or longer ☐ Not currently on teriparatide, abaloparatide or another osteoporosis drug

CHECK ONE DRUG

PROLIA *denosumab* SubQ · 2× a year	☐ **60 mg subcutaneously every 6 months** Next dose due: _____ ☐ Biosimilar OK ☐ Brand Prolia only Many plans now require a denosumab biosimilar first. If eGFR is under 30 or the patient is on dialysis, tell us.	☐ M81.0 Osteoporosis, no fracture ☐ M80.08XA With vertebral fracture ☐ M81.8 Other / drug-induced ☐ Z79.52 Long-term steroid use **ICD-10:** _____
EVENITY *romosozumab-aqqg* SubQ · monthly	☐ **210 mg subcutaneously once a month** — two 105 mg injections 12 doses only. This is dose _____ of 12. ☐ No heart attack or stroke in the past year **Most plans want a bisphosphonate and denosumab both tried first — fill in the box above or this gets denied.**	☐ M81.0 Osteoporosis, no fracture ☐ M80.08XA With vertebral fracture **ICD-10:** _____
RECLAST *zoledronic acid* IV · ≥ 15 min	☐ **5 mg IV once a year** — treatment ☐ **5 mg IV once every 2 years** — prevention ☐ **5 mg IV single dose** — Paget's disease **Not given if creatinine clearance is under 35. Patient drinks two glasses of water beforehand.**	☐ M81.0 Osteoporosis, no fracture ☐ M80.08XA With vertebral fracture ☐ M81.8 Other / drug-induced ☐ M88.9 Paget's disease of bone **ICD-10:** _____
OTHER	Drug: _____ Dose: _____ Route: ____ Every ____ wks	**ICD-10:** _____

PLEASE ATTACH

☐ Face sheet ☐ Insurance cards ☐ Office notes ☐ Medication list ☐ Recent labs ☐ DXA report

SIGNATURE we cannot schedule without it

PRESCRIBER SIGNATURE	DATE	DISPENSE AS WRITTEN
X		☐ Yes

By signing, you authorize LIVbetter Infusions to act as your prior authorization and specialty pharmacy designated agent with insurance companies and to select the site of care.