Referral Status:			MRN:
New referral	Order change	Order Renewal	
Patient preferred clinic:			

Prolia® (denosumab) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:		
Patient Name:		Address:		
Date of Birth:		City, State, Zip:		
Height in inches:	Weight: LB or KG	Gender:	Allergies:	See list / NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

	M81.0 - Age-related Osteoporosis without current fractures		Z79.818 - Long-term use of agents affecting estrogen receptors and estrogen levels
	C50 - Breast Cancer		
	C61 - Malignant neoplasm of the Prostate		Z79.899 - Long-term current use of other medications
	_______ - Other:		

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Most recent Bone Density Scan result
6	Calcium levels drawn within 60 days prior to 1st Injection then annually

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
	NEXT INJECTION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient ***may be ineligible*** to receive Prolia® if serum calcium levels are sub-therapeutic, receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection.

DOSE/FREQUENCY:

☑ Prolia® (denosumab) 60mg subcutaneously every 6 months.

Administer as subcutaneous injection only to upper arm, upper thigh, or abdomen.

SPECIAL ORDERS:

☐ ____

LAB PARAMETERS: (Pharmacist to perform clinical lab monitoring)

Serum Calcium is below normal range: dose will be held unless written clearance is provided by MD

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)

		DATE
Dispense as written/Brand medically necessary	Substitution permitted	

Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com

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