Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

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: REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:

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. ONJ is a risk for patients on denosumab. A routine oral exam is recommended to be performed by the prescriber prior to start of treatment

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)

☐ Check here to indicate the prescriber will be responsible for clinical lab monitoring

If serum Calcium is below normal range, dose will be held unless signed and dated clearance is provided by prescriber.

☑ Refills x 12 months unless noted otherwise here:

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion 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	