

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/> 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: <input type="checkbox"/> See list <input type="checkbox"/> NDKA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> 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:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	REQUIRED	LAST INJECTION DATE:
3	Full medication list	WASHOUT FROM	NEXT INJECTION DATE:
4	Tried and failed therapies	PREVIOUS	<b>IF ORDER CHANGE:</b>  <b>Continue current order until insurance approved</b>
5	Most recent Bone Density Scan result	THERAPY:	
6	Calcium levels drawn within 60 days prior to 1st Injection then annually		

### 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 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	



# Palmetto

## INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

[www.PalmettoInfusion.com](http://www.PalmettoInfusion.com)