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

# Xgeva® (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 )

| | | | |
|---|---|---|---|
| ☐ | C90._____ - Multiple myeloma | ☐ | E83.52 - Hypercalcemia |
| ☐ | C79._____ - Secondary malignant neoplasm of _____ | | |
| ☐ | D48.0 - Neoplasm of uncertain behavior of bone and articular cartilage | | |
| ☐ | _____ - Other: | | |

## REQUESTED DOCUMENTATION:

| | |
|---|---|
| 1 | Insurance information |
| 2 | Most recent History & Physical |
| 3 | Full medication list |
| 4 | Tried and failed therapies |
| 5 | Documentation of Calcium and Vitamin D replacement |

## PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO: PLEASE STATE 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 Xgeva® if serum calcium levels are sub-therapeutic, receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection. Treat hypocalcemia, hypovitaminosis D, and other disturbance of bone and mineral metabolism before starting therapy.**

### DOSE/FREQUENCY:

☐ Xgeva® (denosumab) 120 mg subcutaneously every 4 weeks with additional 120 mg doses on Days 8 and 15 of the first month of therapy.

☐ Xgeva® (denosumab) 120 mg subcutaneously every 4 weeks.

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

### SPECIAL ORDERS:

☐ _____

**Clinical Lab Monitoring of serum Calcium level to be performed by ordering physician, it is recommended to hold dose if serum calcium is subtherapeutic.**

☑ 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 | |

ACCURX
INFUSION CENTER
A PALMETTO INFUSION COMPANY

# 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

02/08/2023