Palmetto INFUSION®

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

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:	IF YES:
PLEASE STATE 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 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.

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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:

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	