

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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 2<sup>ND</sup> AND 3<sup>RD</sup> 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:

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

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INJECTION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INJECTION DATE:
4	Tried and failed therapies	FROM PREVIOUS	
5	Documentation of Calcium and Vitamin D replacement	THERAPY:	
			<b>IF ORDER CHANGE:</b>
			<b>Continue current order until insurance approved</b>

### 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:

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**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 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)