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

Rev 3.4.25

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 ☐ NKDA

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
☐	C61 - Malignant neoplasm of the Prostate		
☐	C50.919 Malignant neoplasm of unspecified site of unspecified female breast	☐	Z79.899 - Long-term current use of other medications
☐	_____ - Other:		

REQUIRED 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:	IF YES:
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 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.

☐ Prescriber clearance waived for recent or planned dental procedures.

SPECIAL ORDERS:

☐ _____

LAB PARAMETERS:

☐ 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:

CARE ORDERS:

☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.

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 1.800.521.9640

- [ ] **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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com