

OSTEOPOROSIS ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____

HT: _____ in WT: _____ kg Sex : Male Female Allergies: NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 CODE + DESCRIPTION) _____ Date of Diagnosis: _____

PERTINENT MEDICAL HISTORY

Does patient have venous access? YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER: _____

a) ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY

PRESCRIPTION ORDERS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
<input type="checkbox"/>	RECLAST (ZOLEDRONIC ACID) ADMINISTER OVER NO LESS THAN 15 MINUTES BUN, CREAT, AND CALCIUM LEVEL WITHIN 90 DAYS OF APPOINTMENT HOLD IF CALCIUM LEVELS < <u>8.5mg/dL</u> or IONIZED CALCIUM LEVEL < <u>4.5mg/dL</u> or IF CRCL < <u>35 ML/MIN</u>	5 mg	IV	ONCE EVERY 12 MONTHS	1 Year
<input type="checkbox"/>	PROLIA (DENOSUMAB) BUN, CREAT, CALCIUM LEVEL WITHIN 90 DAYS OF THE APPOINTMENT HOLD IF CALCIUM LEVELS < <u>8.5mg/dL</u> or IONIZED CALCIUM LEVEL < <u>4.5mg/dL</u> or IF CRCL < <u>30 ML/MIN</u>	60 mg	SC	ONCE EVERY 6 MONTHS	1 Year
<input type="checkbox"/>	EVENTY BUN, CREAT, CALCIUM LEVEL WITHIN 90 DAYS OF THE APPOINTMENT HOLD IF CALCIUM LEVELS < <u>8.5 mg/dL</u> or IONIZED CALCIUM LEVEL < <u>4.5 mg/dL</u> or IF CRCL < <u>30 ML/MIN</u>	210 mg	SC	ONCE EVERY MONTH x 12	1 Year

LAB ORDERS: Calcium, BUN, Serum Creatinine will be drawn prior to administration if previous results not provided within 90 days of appointment.

SUPPORTING DOCUMENTATION FOR PATIENTS RECEIVING RECLAST, PROLIA, OR EVENTY:

- 1) **OSTEOPOROSIS:**
 - CALCIUM, BUN, AND SERUM CREATININE MUST BE CHECKED WITHIN THE LAST 90 DAYS OF THE APPOINTMENT
 - ORIGINAL BONE DENSITY/DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS
 - H+P OR OFFICE NOTES LISTING THE DIAGNOSIS OF OSTEOPOROSIS IN THE PATIENT RECORD DATED WITHIN 1 YEAR PRIOR TO APPOINTMENT
 - PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS MUST BE DOCUMENTED IN PATIENT'S MEDICAL RECORD
(Examples: Oral calcium, Vitamin D, Bisphosphonates)
- 2) MEN AT HIGH RISK OF FRACTURE RECEIVING ANDROGEN DEPRIVATION THERAPY FOR NONMETASTATIC PROSTATE CANCER
- 3) TREATMENT TO INCREASE BONE MASS IN WOMEN AT HIGH RISK FOR FRACTURE RECEIVING AROMATASE INHIBITOR THERAPY FOR BREAST CANCER

*OSTEOPENIA IS NOT AN APPROVED DIAGNOSIS FOR PROLIA (DENOSUMAB). PATIENTS WITH IMPRESSIONS OF OSTEOPENIA MUST HAVE AN ORIGINAL BONE DENSITY RESULT OR DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS OR DOCUMENTATION OF A PREVIOUS FRAGILITY FRACTURE.

*PLEASE SUBMIT DOCUMENTATION OF ANY TRIED AND FAILED ORAL / INJECTIBLE MEDICATIONS ALONG WITH THE SUPPORTING DOCUMENTATION OF THE PATIENT RESPONSE / FAILURE TO TREATMENT.

*PROLIA, RECLAST, AND EVENTY ARE CONTRAINDICATED IN PATIENTS WITH HYPOCALCEMIA.

*EVENTY SHOULD NOT BE ADMINISTERED TO PATIENTS WHO HAVE A HISTORY OF STROKE OR MI (MYOCARDIAL INFARCTION) WITHIN THE LAST 12 MONTHS.

Physician's Signature _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Fax completed form, supporting documentation, faxesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.