

**Fairfield**  
1817 Black Rock Turnpike  
Suite 204  
Fairfield, CT 06824

**Greenwich**  
469 W Putnam Ave  
Ste 205,  
Greenwich, CT 06830



# Medication Orders

# DENOSUMAB

Date: \_\_\_\_\_

### PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

### REFERRAL STATUS

New Referral  Referral Renewal  Medication/Order Change  Benefits Verification Only  Discontinuation Order

### PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

### DENOSUMAB IV BRANDS:

Prolia  Jubbonti  Stoboclo  Bilydos  Ospomyv  Conexence  Bosaya  Enoby  Boncresa

**DIAGNOSIS** *Please provide ICD-10 code*

Age related Osteoporosis without current pathological fracture  
ICD10 Code: M81.0

Age related Osteoporosis with current pathological fracture  
ICD10 Code: M80.0

Other Diagnosis: \_\_\_\_\_  
ICD10 Code: \_\_\_\_\_

**DOSAGE:**

60mg SubQ every 6 months

**Refills:**

X 6 months  
 X 1 year  
 \_\_\_\_\_ doses

**PATIENT WEIGHT**

\_\_\_\_\_ lbs.  
\_\_\_\_\_ kg

### REQUIRED DOCUMENTATION CHECKLIST:

\_\_\_\_\_ This signed order form by the provider

\_\_\_\_\_ Patient demographics AND insurance information

\_\_\_\_\_ Serum creatinine and serum calcium level

\_\_\_\_\_ Documentation of oral hygiene

\_\_\_\_\_ Clinical/Progress notes

\_\_\_\_\_ Labs and Tests supporting primary diagnosis

\_\_\_\_\_ DEXA scan results and/or FRAX score

\_\_\_\_\_ Menopause: Age \_\_\_\_\_

\_\_\_\_\_ Hysterectomy: Age \_\_\_\_\_

**NOTES/ADDITIONAL COMMENTS:**

List Tried & Failed Therapies, including duration of treatment (please comment specifically on bisphosphonates):

1) \_\_\_\_\_

2) \_\_\_\_\_

*If the medication selected above is not covered or is non-preferred by the patient's insurance, the prescribing provider authorizes consideration of the clinically appropriate alternatives listed below. Final medication selection will be based on provider clinical judgment and/or payer requirements. Provider signature below confirms authorization for the above substitution(s), if applicable.*

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### ORDERING PROVIDER

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_