Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

Medication Orders

DENOSUMAB

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ 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** ☐ **Bildyos** ☐ **Ospomyv** ☐ **Conexxence** ☐ **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: _____

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_____

DOSAGE:

☐ 60mg SubQ every 6 months

Refills:

☐ X 6 months
☐ X 1 year
☐ _____ doses

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 _____