Center City
1528 Walnut Street
Suite 1205
Philadelphia, PA 19102

ThrIVewell INFUSION

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

Mission Medical

King Of Prussia
216 Mall Blvd
Suite#1
King Of Prussia, PA, 19046

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: _____

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 _____