

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.

DENOSUMAB IV BRANDS:

Prolia Jubbonti Stoboclo Bilydos Ospomyv Conexence Bosaya Enoby Boncresa

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____