Local Infusion

MYLOCALINFUSION.COM

# DENOSUMAB (AND BIOSIMILAR) ORDER FORM

❑ Conexxence (denosumab-bnht) ❑ Stoboclo (denosumab-bmwo) ❑ Jubbonti (denosumab-bbdz)
❑ Prolia (denosumab)
❑ **Dispense As Written (DAW)**
Will substitute for biosimilar or reference product based on insurance and availability

## PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

## DIAGNOSIS (Provider must specify)

❑ Osteoporosis, with pathological fx, ICD 10: M80._____

❑ Osteoporosis, without pathological fx, ICD 10: M81._____

❑ If M80. _____, location of previous fracture: _____

## PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

**Prerequisites to treatment –** ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

## PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO ❑ Famotidine 20 mg IV ❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Benadryl 25mg PO ❑ Cetirizine (Zyrtec) 10 mg PO

❑ Other: _____ Dose: _____ Route: _____

## MEDICATION

| MEDICATION | DOSE | ROUTE | FREQUENCY |
|---|---|---|---|
| Denosumab | 60 mg | Subcutaneous Inj | Every 6 months |

## LABS / SPECIAL INSTRUCTIONS