SPECIALTY INFUSION CENTER
An Access Infusion Care Company

DENOSUMAB ORDERS

CENTERS AT SIC
An Access Infusion Care Managed Company

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ CBC,CMP within 30 days of admin (SCr and Ca), documentation of Ca and VitD supplementation
☐ DEXA scan results, fracture documentation (if applicable)
☐ Completed and Signed Referral
Typical Payable Dx Codes: M80.0 Age related Osteoporosis w/ fracture M81.0 Age-related osteoporosis without current pathologic fracture M81.8 Other osteoporosis without pathologic fracture M85.9 Disorder of bone density and structure, unspecified
Note: Contraindications- Hypocalcemia and Creatinine Clearance < 35 ml/min
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (855) 857-3834

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change

First dose? ☐ Yes ☐ No - Date of last injection:

DIAGNOSIS

☐ Dx Code/description:

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics and insurance/info ☐ H&P/labs/tests/progress notes supporting Dx

Prior Therapies (include oral bisphosphonates):

☐ Confirm patient is taking Vitamin D/Calcium supplementation	☐ Dexa Scan results within 2 years
☐ Creatinine and Calcium level within 30 days of administration	☐ Fracture History (if applicable)

PRESCRIBING INFORMATION

LAB ORDERS

☐ Creatinine and Calcium Level prior to administration

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☐ **Denosumab** ☐ **Specific Product (optional):**	60mg/mL	☒ 60 mg Inject subcutaneously every 6 months	☒ 1PFS Refills: 1

If not specified, order will be valid for 1 year from the date of signature.
If no product is specified, an insurance-preferred biosimilar may be used.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/5mLHeparin 100u/mL(Port)final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mLIV over 30-60 min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mLIV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain $SpO_2$95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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