

OSTEOPOROSIS INFUSION ORDER FORM

****REQUIRED INFORMATION****

Patient demographics & insurance information This signed order form from the provider
 DXA scan (-2.5T score or more severe) Labs: CMP/CBC within 60 days of treatment
 Documentation to support primary diagnosis (Clinical/progress notes, other medications tried & failed, labs and diagnostic tests, etc.)

Patient Name: _____ DOB: _____

Allergies: NKDA _____ Phone: _____

Insurance: _____ Patient's Weight: _____ lb/kg

Name and Date of last treatment: _____

PREVIOUS TREATMENTS

Alendronate (Fosamax) Risedronate (Actonel, Atelvia) Ibandronate (Boniva) IV ORAL
 Zoledronic acid (Reclast, Zometa) Teriparatide (Forteo) Denosumab (Prolia, Xgeva)
 Abaloparatide (Tymlos)
 Other: _____

PRIMARY DIAGNOSIS

Glucocorticoid-induced osteoporosis (M81.8) Paget's disease of bone (M88.88) Age-Related Osteoporosis (M81.0)
 Other: _____

RECLAST IV (J3488)

Reclast 5mg/100mg IV once yearly
 Reclast 5mg/100mg IV every two years
 Other: _____

PROLIA SUB-Q (J0897)

Prolia 60mg subcutaneous injection Q6mo
 Other: _____

BONIVA IVP (J1740)

Boniva 3mg IVP Q3mo
 Other: _____

EVENTY (J3111)

Evenity 210mg Sub-Q
 Other: _____

Physician Name _____ Phone _____ Fax _____
 Signature _____ Date _____