



Denosumab Injection (Prolia, Jubbonti, Wyost)

Referral Fax: 256-415-6415
Phone: 256-415-6542

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

Patient Sex: _____ Patient Weight: _____ kg Patient Height: _____ in Patient Email: _____

Patient Status: New Patient Continuing Therapy Last Injection Date (if applicable): _____

*** MAY ATTACH DEMOGRAPHIC SHEET

DIAGNOSIS DETAILS

Age-related osteoporosis without current pathological fracture (ICD-10 Code: M81.0)

Age-related osteoporosis with current pathological fracture (ICD-10 Code: M80.0)

Adverse effect of glucocorticoids and synthetic analogues (ICD-10 Code: T38.0X5A)

Other (specify ICD Code) _____

Allergies: _____

Order details for Denosumab: Allow Pharmacy selection based on Insurance coverage

Denosumab : 60 mg Subcutaneous every 6 months Subcutaneous injection

Refills: x1 x2 x3 x4

Patient is currently taking Calcium/Vitamin D Supplement: Yes No

Pre-medications:

Acetaminophen 650mg PO

Diphenhydramine 25mg PO or IV

Hydrocortisone 100mg IV

Methylprednisolone 125mg IV

Other Pre-medications: _____

Infusion Reaction Protocol:

MKIC Reaction Protocol

Other Reaction orders _____

ANCILLARY ORDERS

Lab Orders: _____

Additional Orders: _____

PROVIDER INFORMATION

ProviderName: _____ NPI# _____

Signature: _____ Date: _____

Contact Person: _____ Contact Ph: _____ Email: _____

Office Ph: _____ Office Fax: _____



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REQUIRED DOCUMENTATION FOR EXPEDITED ORDER PROCESSING & INSURANCE APPROVAL

- Include completed order, signed by provider (page 1)
- Include patient insurance information
- Include patient's medication list
- Supporting clinical notes (H&P) support primary diagnosis
 - Original Diagnostic T-Score: _____ T-Score Date: _____
 - History of osteoporotic fracture Prior Osteoporosis Therapy (if any):
 - Generic alendronate
 - Fosamax® (alendronate sodium)
 - Actonel® (risedronate sodium)
 - Boniva® (ibandronate sodium)
 - Other _____
 - Reason for Discontinuing Previous Osteoporosis Therapy(ies): _____
 - Contraindications (if any): _____
 - Patient is currently taking calcium and vitamin D supplements: Yes No
 - Calcium level available:
 - Yes No Other pertinent information: _____
- Include labs and/or test results to support diagnosis
- Other medical necessity: _____

ADDITIONAL REQUIRED INFORMATION

- Calcium levels (within 6 months) & DEXA Scan**

Montgomery Keeton Infusion Center will provide all necessary documents to the patient's insurance company to confirm eligibility. MKIC will inform you if further details are needed. Additionally, we'll discuss financial obligations with the patient and direct them to co-pay assistance options as required.

Please submit BOTH pages & ALL supporting documentation.

Fax to 256-415-6415 or Email to info@mkinfusion.com