

# OSTEOPOROSIS INFUSION ORDER FORM

**\*\*REQUIRED INFORMATION\*\***

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

Allergies: NKDA \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance: \_\_\_\_\_ Patient's Weight: \_\_\_\_\_ lb/kg

Name and Date of last treatment: \_\_\_\_\_

**PREVIOUS TREATMENTS**

<input type="checkbox"/> Alendronate (Fosamax)	<input type="checkbox"/> Risedronate (Actonel, Atelvia)	<input type="checkbox"/> Ibandronate (Boniva) <input type="checkbox"/> IV <input type="checkbox"/> ORAL
<input type="checkbox"/> Zoledronic acid (Reclast, Zometa)	<input type="checkbox"/> Teriparatide (Forteo)	<input type="checkbox"/> Denosumab (Prolia, Xgeva)
<input type="checkbox"/> Other: _____		

**PRIMARY DIAGNOSIS**

Glucocorticoid-induced osteoporosis (733.09)   
  Paget's disease of bone (731.0)   
  Senile Osteoporosis (733.01)

**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: \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_