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)

☐ 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 _____

Infusion Solutions OF DELAWARE, LLC

1100 Forrest Avenue, Dover, DE 19904
Phone: 302-674-4627
Fax: 302-674-4628