

# DENOSUMAB PRESCRIBER ORDER FORM

Patient Name:		Date of Birth:	Gender:	
Address:				
Phone:	Height:	<input type="checkbox"/> Inches <input type="checkbox"/> cm		Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg
<b>Clinical Information</b>				
Primary Diagnosis Description:		ICD-10 Code:		
Allergies: <input type="checkbox"/> NKDA OR (List): _____				
<b>Denosumab Prescription</b>				
<input type="checkbox"/> Denosumab (Jubbonti®) biosimilar as permitted by patient's insurance <input type="checkbox"/> Denosumab (Prolia®)  <input type="checkbox"/> Inject 60mg subcutaneously in the upper arm, upper thigh, or abdomen by a healthcare professional once every 6 months. Refill x 1 year. <input type="checkbox"/> Other: _____				
<b>Xgeva® (Denosumab) Prescription</b>				
<input type="checkbox"/> Denosumab (Xgeva®) <input type="checkbox"/> Inject 120mg every 4 weeks subcutaneously in the upper arm, upper thigh, or abdomen by a healthcare professional. Refill x 1 year. <input type="checkbox"/> Inject 120mg every 4 weeks, with additional 120mg doses on days 8 and 15 of the first month of therapy, subcutaneously in the upper arm, upper thigh, or abdomen by a healthcare professional. Refill x 1 year.				
<b>Ancillary Orders</b>				
<b>Anaphylaxis Kit</b> If this is a 1 <sup>st</sup> dose, would you like Option Care Health to provide an anaphylaxis kit with the 1 <sup>st</sup> dose? <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> <li>▪ Epinephrine 0.3 mg (&gt; 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (&lt; 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.</li> <li>▪ Diphenhydramine 25 mg (&gt; 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.</li> <li>▪ 0.9% Sodium Chloride 500 mL (&gt; 30 kg) or 250mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.</li> </ul>				
<b>Lab Orders</b> <input type="checkbox"/> No labs ordered at this time. <input type="checkbox"/> Other: _____				
Skilled nurse to assess and administer as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year. If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.				
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>				
Prescriber Signature: _____			Date: _____	
<b>Prescriber Information</b>				
Prescriber Name:		Phone:	Fax:	
Address:		NPI:		
City, State:	Zip:	Office Contact:		
<b>Fax completed form, insurance information, and clinical documentation to: 713-983-4647</b>				
<small><b>CONFIDENTIAL HEALTH INFORMATION:</b> Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. <b>IMPORTANT WARNING:</b> This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.</small>				