DENOSUMAB PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		

Phone:	Height:	☐ Inches ☐ cm	Weight:	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

Allergies: ☐ NKDA OR (List):

Denosumab Prescription

☐ **Denosumab (Jubbonti®) biosimilar as permitted by patient's insurance**
☐ **Denosumab (Prolia®)**

☐ Inject 60mg subcutaneously in the upper arm, upper thigh, or abdomen by a healthcare professional once every 6 months. Refill x 1 year.
☐ Other: _____

Xgeva® (Denosumab) Prescription

☐ **Denosumab (Xgeva®)**
- ☐ Inject 120mg every 4 weeks subcutaneously in the upper arm, upper thigh, or abdomen by a healthcare professional. Refill x 1 year.
- ☐ 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.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Lab Orders

☐ No labs ordered at this time.
☐ 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 certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	**NPI:**	

City, State:	Zip:	Office Contact:

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

