

INFUSION & MEDICAL CENTER

| 1. | Patient Name | | DOB | Pa | tient Phone/Cel | l # | |
|----|---|--------------------------|--------------------------|------------------------|--------------------|-----------|--|
| | Patient demographic and insurance information to be faxed with Infusion Order Form | | | | | | |
| 2. | Medical Information (Please select primary diagnosis and complete ICD10 Code): | | | | | | |
| | Primary Diagnosis:Age-related Osteoporosis with current fractureAge-related Osteoporosis without current fracture | | | | ICD-10 Code: M80.0 | | |
| | | | | | | | |
| | | Other: | · | | ICD-10 Code: | | |
| | Allergies: | | | (or attach list) | | | |
| 3. | Clinical Information - | - Please fax with Inf | usion Order Form: | _ | | | |
| | Clinical MD Notes, labs, test supporting primary diagnosis | | | | Patient | | |
| | Documentation of t | aled and failed | | Weight: | lbs. | | |
| | Dexa Scan Results indicating osteoporosis | | | | _ | | |
| | Recent serum calcium | | | | Height: | 111. | |
| | Current medication list: | | | | | | |
| | Patient is currently receiving calcium/vitamin D supplementation: | | | | | | |
| | Yes No Other: | | | | | | |
| | Was the patient previously receiving a bisphosphonate: \(\bigcap \) Yes \(\bigcap \) No | | | | | | |
| | If yes, therapy was discontinued: | | | | | | |
| | If yes, desired wash-out period prior to starting Prolia:weeks | | | | | | |
| | | PROL | .IA® (denosumab) | | J Cod | de: J0897 | |
| 4. | Drug Order: | | | | | | |
| | Prolia (denosumab): 60 mg every six months # Refills (Recommend 1) | | | | | | |
| | Administer 60 mg subcutaneously every six months | | | | | | |
| | _ | njection: | | | | | |
| | Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol | | | | | | |
| | | | | | | | |
| | By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers. | | | | | | |
| | to serve as r | ny prior authorization a | agent with medical and p | ilaiiliacy ilis | diance providers. | | |
| 5. | Physician Signature: | | // | | Date: | | |
| | Physician Signature: | | Substituti | Substitution permitted | | | |
| | Printed Physician's Name: | | C | ontact Phor | ne #: | | |
| | | | | | | | |
| | | | | | | | |

FAX ALL INFORMATION CENTRAL FAX 803.999.1754

INFUSION CENTER LOCATIONS

BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760