INTRAMED Plus
infusion services

XGEVA®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

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: _____Hypercalcemia of Malignancy ICD-10 Code: E83.52 _____
_____Giant Cell Tumor of Bone ICD-10 Code: M27.1 _____
_____Other: ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
- Documentation of therapies previously trialed and failed
- Dexa Scan Results indicating osteoporosis
- Recent serum calcium
- Current medication list:
  - Patient is currently receiving calcium/vitamin D supplementation:
    ❑ Yes ❑ No ❑ Other: _____

Patient
Weight: _____ lbs.
Height:_____ in.

XGEVA® (denosumab) J Code: J0897

4. Drug Order:

Xgeva (denosumab): 120 mg administered subcutaneously _____ # Refills (Recommend 6)

❑ **New Patient**
Administer on week 0, week 1, week 2, week 4 and then every 4 weeks thereafter

❑ **Ongoing Patient**
Administer every four weeks

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.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX **803.999.1754**	**INFUSION CENTER LOCATIONS** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**