INTRAMED Plus
infusion services

PROLIA®

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: _____Age-related Osteoporosis with current fracture ICD-10 Code: M80.0 _____
_____Age-related Osteoporosis without current fracture ICD-10 Code: M81.0 _____
_____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: _____
  - Was the patient previously receiving a bisphosphonate: ❑ Yes ❑ No
    If yes, therapy was discontinued: _____
    If yes, desired wash-out period prior to starting Prolia: _____weeks

Patient
Weight: _____ lbs.
Height:_____ in.

PROLIA® (denosumab) J Code: J0897

4. Drug Order:

Prolia (denosumab): 60 mg every six months _____ # Refills (Recommend 1)

Administer 60 mg subcutaneously every six months

Date of last Prolia injection:_____ ❑ N/A

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.

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**