INTRAMED Plus
infusion services

DENOSUMAB

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 without current fracture ICD-10 Code: M81.0 _____
_____ Age-related Osteoporosis with current fracture ICD-10 Code: M80.0 _____
_____ Other:_____ ICD-10 Code: _____
Allergies: _____ (or attach list)

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

- Clinical documentation supporting primary diagnosis
- Documentation of tried and failed therapies
- Recent Lab/Test Results including:
  - o DEXA Scan Results indicating osteoporosis
  - o Serum calcium prior to 1st injection then annually
  - o Kidney Function: SCr/eGFR
- Medication List
  - o Patient currently receiving 1000 mg calcium & 400 IU vitamin D supplementation:
    ❑ Yes ❑ No ❑ Other: _____

Patient
Weight: _____ lbs.
Height: _____ in.

4. Drug Order:

FDA Approved Interchangeable Biosimilars: *may be required due to patient's insurance
❑ **Bildyos® (Q5162),** ❑ **Jubbonti® (Q5136),** ❑ **Other:** _____
❑ **Prolia®(J0897)**

Administer 60 mg subcutaneously in the upper arm, upper thigh, or abdomen once every six months
Doses Authorized: 2 (two)

Date of last Prolia/denosumab injection: _____ ❑ N/A

Skilled nurse to assess and administer as indicated above. Nurse will provide ongoing support as needed. If patient is seen within a provider led infusion clinic, Intramed Plus' infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.
Anaphylaxis Kit:
- 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 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

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 with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE	
CENTRAL FAX **803.999.1754**	**803.999.1750**	Access Intramed Plus prescription order forms here.