SHERIDAN COMMUNITY HOSPITAL
OUTPATIENT INFUSION CENTER
PHONE: 989.291.6295 FAX: 877.249.1191

☐ **STAT REFERRAL**

OSTEOPOROSIS / OSTEOPENIA ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: ____ DOB: _____

HT: _____ in WT: _____ ☐ lbs ☐ kg Sex: ☐ Male ☐ Female Allergies: ☐ NKDA, _____

_____

Physician Name: _____ Contact Name: _____ Contact Phone #: _____

NPI #: _____ Tax ID #: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 CODE + DESCRIPTION)

_____ Date of Diagnosis: _____

PERTINENT MEDICAL HISTORY

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

a) ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY
b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

PRESCRIPTION ORDERS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
☐	**RECLAST (ZOLEDRONIC ACID)** ADMINISTER OVER NO LESS THAN 15 MINUTES BUN, CREAT, AND CALCIUM LEVEL WITHIN 90 DAYS OF APPOINTMENT HOLD IF CALCIUM LEVELS < 8.5mg/dL or IONIZED CALCIUM LEVEL < 4.5mg/dL or IF CRCL < 35 ML/MIN	**5 mg**	**IV**	**ONCE EVERY 12 MONTHS**	**1 Year**
☐	***SELECT ONE:* (DENOSUMAB)** ☐ **PROLIA** ☐ **CONEXXENCE** ☐ **JUBBONTI** ☐ **STOBOCLO** ☐ **BILDYOS** ☐ **ENOBY** ☐ **OSPOMYV** BUN, CREAT, CALCIUM LEVEL WITHIN 90 DAYS OF THE APPOINTMENT. HOLD IF CALCIUM LEVELS < 8.5mg/dL or IONIZED CALCIUM LEVEL < 4.5mg/dL or IF CRCL < 30 ML/MIN	**60 mg**	**SC**	**ONCE EVERY 6 MONTHS**	**1 Year**
☐	**EVENITY** BUN, CREAT, CALCIUM LEVEL WITHIN 90 DAYS OF THE APPOINTMENT HOLD IF CALCIUM LEVELS < 8.5 mg/dL or IONIZED CALCIUM LEVEL < 4.5 mg/dL or IF CRCL < 30 ML/MIN	**210 mg**	**SC**	**ONCE EVERY MONTH x 12**	**1 Year**

LAB ORDERS: Calcium, BUN, Serum Creatinine will be drawn prior to administration if previous results not provided within 90 days of appointment.

SUPPORTING DOCUMENTATION FOR PATIENTS RECEIVING RECLAST, PROLIA, OR EVENITY:

1) **OSTEOPOROSIS / OSTEOPENIA:**

- **CALCIUM, BUN, AND SERUM CREATININE MUST BE CHECKED WITHIN THE LAST 90 DAYS OF THE APPOINTMENT**
- **ORIGINAL BONE DENSITY/DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS OR OSTEOPENIA.**
- **ORIGINAL 10 YEAR FRAX PROBABILITY SUPPORTING HIGH RISK FOR FUTURE FRACTURES (OSTEOPENIA DIAGNOSIS).**
- **H+P OR OFFICE NOTES LISTING THE DIAGNOSIS OF OSTEOPOROSIS OR OSTEOPENIA IN THE PATIENT RECORD DATED WITHIN 1 YEAR PRIOR TO APPOINTMENT**
- **PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS OR OSTEOPENIA MUST BE DOCUMENTED IN PATIENT'S MEDICAL RECORD (Examples: Oral calcium, Vitamin D, Bisphosphonates)**

2) **MEN AT HIGH RISK OF FRACTURE RECEIVING ANDROGEN DEPRIVATION THERAPY FOR NONMETASTATIC PROSTATE CANCER**

3) **TREATMENT TO INCREASE BONE MASS IN WOMEN AT HIGH RISK FOR FRACTURE RECEIVING AROMATASE INHIBITOR THERAPY FOR BREAST CANCER**

***OSTEOPENIA IS AN APPROVED DIAGNOSIS FOR RECLAST (ZOLEDRONIC ACID) WITH AN ASSOCIATION TO EITHER LOWER ENERGY FRACTURE (FRAGILITY FRACTURE) OR A HIGH RISK FOR FUTURE FRACTURES INDICATED BY THE PATIENTS 10 YEAR FRAX PROBABILITY.**

***OSTEOPENIA IS NOT AN APPROVED DIAGNOSIS FOR PROLIA (DENOSUMAB) OR EVENITY. PATIENTS WITH IMPRESSIONS OF OSTEOPENIA MUST HAVE AN ORIGINAL BONE DENSITY RESULT OR DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS OR DOCUMENTATION OF A LOWER ENERGY FRACTURE (FRAGILITY FRACTURE).**

***PLEASE SUBMIT DOCUMENTATION OF ANY TRIED AND FAILED ORAL / INJECTIBLE MEDICATIONS ALONG WITH THE SUPPORTING DOCUMENTATION OF THE PATIENT RESPONSE / FAILURE TO TREATMENT.**

***PROLIA IS CONTRAINDICATED IN PATIENTS WITH HYPOCALCEMIA.**

Physician's Signature _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Cosignature (If Required)_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.