Osteoporosis Therapies

Provider Order Form Rev. 08/2024

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Osteoporosis w/ Fracture (M80.0 – M80.8), ICD10 _____ ☐ Other: _____, ICD10 _____

☐ Osteoporosis w/o Fracture, M81.0

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Evenity® (romosozumab)	210 mg	☐ Inject 210mg SUBQ every 1 month x 1 year
Prolia® (denosumab)	60 mg	☐ Inject 60mg SUBQ every 6 months x 1 year
Reclast® (zoledronic acid)	5 mg	☐ Infuse 5mg IV over 15 minutes once a year ☐ Infuse 5mg IV over 15 minutes once every 2 years
OTHER:		

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES**

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

PRE-MEDICATION ORDERS:

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO

☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV

☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ NPI: _____ TIN: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ Osteoporosis is confirmed with a Bone Mineral Density (BMD) test.

☐ The patient is at high risk for fractures. ***Please select all that apply:***

- ☐ History of fragility (non-traumatic) fracture
- ☐ Multiple risk factors for fracture:
  - ☐ anorexia nervosa
  - ☐ alcohol intake (4 or more units/day)
  - ☐ corticosteroid therapy
  - ☐ smoking
  - ☐ elderly
  - ☐ low body mass
  - ☐ parental history of hip fracture
  - ☐ rheumatoid arthritis
  - ☐ Other: _____

LAB AND TEST RESULTS (required)

- Provide copy of Bone Mineral Density (BMD) test
- Provide copy of baseline recent Calcium level
- If patient has a history of kidney disease: provide copy of intact PTH, serum calcium and Vitamin D

PRIOR FAILED THERAPIES (including oral/IV bisphosphonates, SERM)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____