

# Osteoporosis Therapies

Provider Order Form Rev. 07/2025

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



## 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
Denosumab biosimilar available <input type="checkbox"/> Prolia® (denosumab) <input type="checkbox"/> Jubbonti (denosumab-bbdz)	60 mg	<input type="checkbox"/> Inject 60mg SUBQ every 6 months x 1 year
Evenity® (romosozumab)	210 mg	<input type="checkbox"/> Inject 210mg SUBQ every 1 month x 1 year
Reclast® (zoledronic acid)	5 mg	<input type="checkbox"/> Infuse 5mg IV over 15 minutes once a year <input type="checkbox"/> Infuse 5mg IV over 15 minutes once every 2 years

OTHER: \_\_\_\_\_

## OTHER ORDERS

Is patient currently receiving therapy above from another facility?  NO  YES  
If yes, Facility Name: \_\_\_\_\_ Date of last treatment: \_\_\_\_\_ Date of next treatment: \_\_\_\_\_

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  Diphenhydramine 25mg PO  
 Acetaminophen 650mg 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  elderly
    - alcohol intake (4 or more units/day)  low body mass
    - corticosteroid therapy  parental history of hip fracture
    - smoking  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: \_\_\_\_\_