Southwestern Medical Center
Empowered by ScionHealth
Phone: 580-531-4892
Fax: 877-249-1191

☐ **STAT REFERRAL**

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
OSTEOPOROSIS ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI____ DOB:_____

HT: _____ in WT: _____ 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**
☐	**PROLIA (DENOSUMAB)** BUN, CREAT, CALCIUM LEVEL WITIN 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 WITIN 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**

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

1) **OSTEOPOROSIS:**

- **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**
- **H+P OR OFFICE NOTES LISTING THE DIAGNOSIS OF OSTEOPOROSIS IN THE PATIENT RECORD DATED WITHIN 1 YEAR PRIOR TO APPOINTMENT**
- **PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS 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 MADD IN WOMEN AT HIGH RISK FOR FRACTURE RECEIVING AROMATASE INHIBITOR THERAPY FOR BREAST CANCER**

***OSTEOPENIA IS NOT AN APPROVED DIAGNOSIS FOR PROLIA (DENOSUMAB). PATIENTS WITH IMPRESSIONS OF OSTEOPENIA MUST HAVE AN ORIGINAL BONE DENISTY RESULT OR DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS OR DOCUMENTATION OF A PREVIOUS 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.