



Patient Information

Name:
DOB:
Address:
City: State:
Zip: Weight:
Phone:
Allergies:

Prescriber Information

Prescriber Name:
NPI:
Address:
City:
State: Zip:
Phone:
Fax:

Diagnosis (please provide ICD-10 code in space provided):

Osteoporosis

Nursing Orders: Hold infusion and notify provider for:

Signs/symptoms of illness or active infection, planned/recent surgical procedures, cough, night sweats, unintended weight loss, recent live vaccinations, active shingles.

If infusion related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Drug	Dosing	
☐ Denosumab OR denosumab biosimilar *Preferred product TBD after benefits investigation (noted below) ☐ Do not substitute Give the following denosumab product: 	☐ 60mg subcutaneous injection every 6 months	☐ ☐ x 1 year
☐ Evenity (romosozumab)	☐ 210mg subcutaneous injection once monthly If osteoporosis therapy remains warranted, continued therapy with an antiresorptive agent should be considered • Would you like for Allied to transition the patient to denosumab or denosumab biosimilar after 12 doses of Evenity? ☐ Yes ☐ No	☐ ☐ x 12 doses
☐ Zoledronic Acid	☐ Administer Zoledronic Acid 5mg IV over at least 15 minutes x one dose Please include the following labs: • Serum calcium within 60 days prior to each dose • Serum creatine within 60 days prior to each dose	☐ x 1 year

Other orders:

Premedications:

☐ Tylenol 650mg PO ☐ Benadryl 25mg IV or PO ☐ Solu-Medrol IV 40mg, 125mg or mg
☐ Other: IV or PO

Order valid for one year unless otherwise indicated. IV solutions and diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Prescriber Name (Please print): Contact Person:

Prescriber Signature: Date:

Please include a copy of the latest insurance information as well as all applicable clinical notes.

By signing this form, you certify that the use of the selected treatment is medically necessary and you will be supervising the treatment of the patient. Additionally, you authorize Allied Infusion Services to act as your prior authorization designated agent when interacting with medical and prescription payors and patient assistance programs.