

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F
 Ht: _____ Wt: _____ ☐ lbs ☐ kg Primary Language: _____
 Allergies: _____ Patient Preferred Location: _____

Diagnosis

ICD 10 Code (Required)

- ☐ M81.0 Osteoporosis
☐ M80.0 _____ Osteoporosis with Current Pathological Fracture
☐ Other ICD Code: _____
 Description: _____

Medication Order

DRUG	DOSING	REFILLS
☐ Denosumab OR Denosumab Biosimilar * Preferred product TBD after benefits investigation (noted below) ☐ Do Not Substitute Give the following Denosumab product: _____	☐ 60 mg subcutaneous injection every 6 months	☐ _____ ☐ x 1 Year

Required Clinical Documentation

- Include signed and completed order
- Include patient demographic information and insurance information
- Include patient's current medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contradictions to other therapy

LAB RESULTS: Most recent serum calcium and eGFR within 12 months. Bone density scans required every 2 years

Is the patient on any other disease modifying therapy?

☐ Yes ☐ No

If yes, please note therapy and last dose:

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., oral and/or IV bisphosphonate)? ☐ Yes ☐ No
 If yes, which drug(s) _____

- ☐ Patient is currently taking Calcium/Vitamin D supplementation
☐ Yes ☐ No

- Include labs and/or test results to support diagnosis.
- Other medical necessity: _____

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____