PRESCRIPTION ORDER FORM

Denosumab
(Prolia, Jubbonti, Bildyos, etc)

Suite Life
Infusing health and wellness into your life.

Central Fax: 800-504-0870

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- DEXA Scan
- Current Calcium Levels (within 6 weeks)
- Please include tried/failed documentation of IV and/or oral Bisphosphonates

PRIMARY DIAGNOSIS

☐ M81.8 Other osteoporosis without current pathological fracture
☐ M81.0 If Age related osteoporosis without current pathological fracture
☐ Other: _____
*If patient has pathological fracture, please code correctly.

CLINICAL MONITORING

☑ Serum Calcium every 6 weeks to be maintained by ordering provider.

PRE-MEDICATIONS **No Standard premedications typically indicated**

☐ Diphenhydramine 25mg PO
☐ Diphenhydramine 50mg PO
☐ Diphenhydramine 25mg IVP
☐ Diphenhydramine 50mg IVP
☐ Pepcid 20mg PO
☐ Pepcid 20mg IV
☐ Cetirizine 10mg PO
☐ Tylenol 650mg PO
☐ Solu-Cortef 40mg IVP
☐ Solu-Cortef 125mg IVP
☐ Other: _____

PRIMARY MEDICATION ORDER **Prolia or biosimilar may be used in accordance to payor guidelines**

☐ Denosumab 60mg SubQ injection once every 6 months
☐ Other:_____

First Dose: ☐Y ☐N

☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ Provider Signature

_____ Date