

OSTEOPOROSIS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	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 months)

PRIMARY DIAGNOSIS

- M80.00xA Age-related osteoporosis with current pathological fracture, initial encounter
- M80.00xS Age-related osteoporosis with current pathological fracture, sequela
- M81.0 Age-related osteoporosis without current pathological fracture
- Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

*Per infusion clinic protocol: (No recommended standard pre-meds for Evenity, Prolia, or Zoledronic Acid)

Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- Evenity 210 mg (two 105 mg SubQ injections) once monthly for 12 doses
- Prolia 60 mg SubQ injection once every 6 months
- Zoledronic Acid 5 mg IV once yearly
- Other: _____

First Dose: Y N Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.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:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature _____

Date _____