Updated September 17, 2019

Checklist for Prolia (denosumab) Referral

Required documentation for all initial referrals

Patient _____DOB_____ Date_____ □ New Start □ Maintenance

Please return **completed** checklist and checklist items for an infusion referral:

- ☐ Patient demographics (e.g. address, phone number, SSN, etc.)
- ☐ Insurance information and copy of insurance card(s). Please indicate the insurance that is primary, and the insurance that is secondary, if applicable, and the subscriber's date of birth.
  - If insurance requires prior authorization, please provide the phone number and allow up to 15-30 days for this to be completed by one of our Infusion Coordinators.
- ☐ Signed and completed Prolia Standard Order (our order form) with ICD diagnosis code
  - *Standard Order forms are available at lowcountryrheumatology.com/infusions/*
- ☐ Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy, and how long patient has been on Prolia.
- ☐ Lab results and/or tests to support diagnosis.
  - Pre-Screening:
    - **Required lab results within 60 days: Calcium**
    - **Required bone density scan results within last 2 years**
- ☐ Please indicate name and direct phone number of a contact within your office that we can speak with to obtain any additional information:
  - Name: _____
  - Phone Number: _____

Paperwork can be faxed or emailed to (843)-824-2327, infusionemail@articularishealthcare.com

Infusion Coordinators Brenna, Sadie or Stephanie will assist you with any questions at (843)-572-8932

Low Country Rheumatology Infusion Locations

Please mark preferred location and we will do our best to accommodate, however we cannot make any guarantees.

Summerville
2001 2nd Ave, Suite 201, Summerville, SC 29486

Mount Pleasant
1165 Chuck Dawley Blvd, Mt. Pleasant, SC 29464

West Ashley
2291 Henry Tecklenburg Drive, Charleston, SC 29414

Low Country Rheumatology Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our Infusion Coordinators will notify you if any further information is required. The patient will have an annual 30-minute consult with our MD to obtain H&P for chart. We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Thank you for the referral!

Low Country Rheumatology Use Only Existing Patient Yes____ No____ Physician _____

Updated September 17, 2019

Standard Orders for Prolia (denosumab) Administration

Patient _____DOB_____ Date_____

Indication:

□ M81.0 Senile Osteoporosis w/o fracture	□ M81.8 Other Osteoporosis without current fx	□ Other _____
□ M80.0 Age-related Osteoporosis with current fx. Specify code for fx: _____		

History:

Does the patient have any upcoming or ongoing dental exams/procedures? □ Yes □ No

□ Treatment of postmenopausal women with osteoporosis at high risk for fracture
□ Treatment to increase bone mass in men with osteoporosis
□ Treatment of bone loss in men receiving androgen deprivation therapy for prostate cancer
□ Treatment of bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer

Patient must meet ONE of the following:

□ Hip or vertebral fracture
□ Other prior fractures and T-score between -1.0 and -2.5
□ T-score ≥ -2.5 (after appropriate evaluation to exclude secondary causes)
□ T-score between -1.0 and -2.5 and secondary causes associated with high fracture risk
□ T-score between -1.0 and -2.5 WITH a 10-year probability of hip fracture ≥ 3% **or** 10-year probability of any major osteoporotic fracture ≥ 20%, based on FRAX assessment

Patient must have ONE of the following documented:

□ Allergy to shellfish and/or salmon
□ Intolerance of oral bisphosphonates due to medical or surgical conditions
□ Noncompliance with oral bisphosphonate therapy for at least 3 months

Orders:

□ Standard Order Protocol:

- Instruct patient on medication administration, possible side effects, and obtain signed consent for Prolia.
- Verify that labs are current and within normal limits
- Counsel patient to take calcium 1000 mg daily and at least 400 IU vitamin D daily
- Obtain vital signs prior to subcutaneous administration
- Evaluate patient for active infections, prior or upcoming surgical procedures, medication allergies, COPD, or any current health concerns as noted on Infusion Record
- **If infusion reaction occurs initiate infusion reaction protocol per Articularis Healthcare Policy and Procedure Manual.**
- Discharge instructions to include possible injection side effects and follow-up appointment schedule

Dose:

□ Prolia 60 mg in a 1ml solution SQ Injection administered once every 6 months in upper arm, upper thigh or abdomen.

Frequency:

□ Administer Prolia 60 mg subcutaneous every 6 months Date of last injection: _____

Labs:

□ Confirm that Serum Calcium has been completed in the past 60 days and is within normal limits: *attach copy of labs to order.*

Additional orders/comments:

_____

_____

Practice Name: _____

Physician Name: _____

Physician Signature: _____

Date: _____

NPI: _____

State License: _____

DEA #: _____

UPIN: _____