Beaufort Memorial

Outpatient "PROLIA" Treatment Order

Note: Order valid for a maximum of twelve (12) months
Order must be completed in full

Patient Name: _____ **Date of Birth:** _____

General

Allergy: _____

Diagnosis: _____ Diagnosis Code: _____

Measurements: Weight: _____ lbs.; Height: _____ inches;

DEXA scan/T score _____ Date of Dexa scan _____

History of osteoporotic fracture: ◯ Yes ◯ No ◯ Not Known

Prior osteoporosis therapy:
☐ Generic alendronate ☐ Fosamax (alendronate sodium) ☐ Actonel (risedronate sodium)

☐ Boniva (ibandronate sodium) ☐ none ☐ other (specify) _____

Instruct patient:

- Take over-the-counter oral calcium supplement at least 1000 mg daily and over-the-counter oral vitamin D supplement at least 400 IU daily.
- Advise patient to maintain good oral hygiene during treatment with Prolia. Patient to inform their dentist prior to dental procedures that they are receiving Prolia.
- Notify MD if she becomes pregnant while on Prolia therapy.

Nursing Orders

☑ Hypersensitivity/ Anaphylaxis Management for Infusions / Desensitization - Adult Order Set

Medication Orders

◯ **Denosumab** (Prolia) 60 mg every 6 months x 1 dose

◯ **Denosumab** (Prolia) 60 mg every 6 months x 2 doses

•Prior to administration, Prolia may be removed from the refrigerator and brought to room temperature (Up to 25°C/ 77°F) by standing in the original container. Do not warm Prolia in any other way.

•Administer as a subcutaneous injection in the upper arm, upper thigh, or abdomen

MD Print name: _____ Address: _____

Phone #: _____ Fax#: _____

MD Signature: _____ DATE: _____ TIME: _____

ORD

Patient Sticker

Beaufort Memorial

PROLIA PACKET SUBMISSION

- BMH Employed Providers: Fax packet to 843-522-5821
- External Providers: Fax packet to 843-522-5930

Patient Name: _____ Date of Birth: _____

For this patient to be approved and scheduled for a Prolia injection(s), the following must be submitted:

☐ Outpatient Prolia treatment order must be completed in full including diagnosis description, ICD 10 diagnosis code, provider name, provider signature, date, and time.

☐ Completed Prolia insurance verification form and copy of insurance cards, if possible.

☐ Response from Prolia insurance verification form

☐ Office notes (within 12 months of injection) with documentation from the provider as to:

- ☐ Why the provider wants the patient on Prolia.
- ☐ What medications has the patient tried prior to Prolia? If none, documentation must show history of fracture or high risk of fracture.
- ☐ Documentation must support that the patient has been educated on the benefits and risks of Prolia.

Date of documentation: _____

☐ DEXA scan Report

Date of DEXA scan report: _____

***Provider**- if the patient's insurance changes prior to the second injection, you will need to provide a new packet at that time. Your office will be notified prior to that appointment.

For internal use only

◯ Approved 1 injection to schedule.
◯ Approved 2 injections to schedule (2nd in six months from first injection), documentation and DEXA scan meet the time frame.
◯ Denied: missing: _____

ORD

Patient Sticker

Beaufort Memorial

Patient Information ◯ New Patient to Prolia ◯ Existing Patient

*Patient Name: _____

☐ Attach patient demographic sheet **OR** complete information below:

*Street Address: _____

*City: _____ *State: _____ *ZIP: _____

Phone: _____

◯M ◯F *Date of Birth: _____

Fulfillment Method (Select only ONE)

☐Medical Benefit (Physician Purchase)

☐Pharmacy Benefit ☐Out of Network Benefits

☐Referral to treating site:

*Enter Site ID: _____ **OR** Complete information below

*Site Name: _____

*Street Address: _____

*City: _____ *State: _____ *ZIP: _____

*Phone: _____ *Fax: _____

Office Contact: _____

*Site Type: ◯MD Office ◯Hospital Outpatient

Primary Insurance Information

☐Attach a copy of insurance card, front AND back OR provide:

*Insurance Name: _____

*Insurance Phone: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Group #: _____

*Policy Number #: _____

Medicare Beneficiary Identifier: _____

Secondary Insurance Information (if applicable)

☐Attach a copy of insurance card, front AND back OR provide:

*Insurance Name: _____p_____

*Is this a Medigap policy? ◯Yes ◯No ◯Not Known

If yes, please indicate plan letter: _____

*Insurance Phone: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber Relationship to Patient: _____

Group #: _____

*Policy #: _____

Pharmacy Insurance Information

☐Attach a copy of insurance card, front AND back **OR** provide:

*Pharmacy Insurance Patient ID #: _____

*Pharmacy Insurance Phone #: _____

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Physician Information

*Physician Name: _____

*NPI #: _____ Tax ID #: _____

Specialty: _____

*Enter Site ID: _____ **OR** Complete information below

*Site NPI #: _____ Site Tax ID #: _____

*Site Name: _____

*Street Address: _____

*City: _____ *State: _____ *ZIP: _____

*Phone: _____Fax: _____

Office Contact: _____

*Site Type: ◯MD Office ◯Hospital Outpatient

Patient Medical Information†

◯M81.0 (Age-related osteoporosis without current pathological fracture)

◯M80.0 _____ (Age related osteoporosis with current pathological Fracture…) Please provide complete code.

◯Other (Specify ICD Code) _____

Please provide secondary ICD Code, if applicable: _____

Please NOTE: clinical notes and additional documentation are **NOT required** for us to process a patient benefit verification. Review of clinical documentation sent to Amgen SupportPlus could delay our response time back to your office. Please **DO NOT** provide anything beyond the information requested on this benefit verification form.

†The sample diagnosis codes are informational and not intended to be directive or a guarantee of reimbursement and include potential codes that would include FDA approved indications for Prolia®. Other codes may be more appropriate given internal system guidelines, payer requirements, practice patterns, and the service rendered.

Prescription Information

Prolia® 60 mg pre-filled syringe, 60 mg SC every 6 months

Refill: ☐ x1

Prescriber Signature: (required for legal prescription triage)

℞_____ Date: _____

Patient Sticker