RELIANT SPECIALTY INFUSION

**AIC Denosumab** **Fax: 833-808-0833**

## Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

## Medical Assessment

Diagnosis:

- ❑ M81.0 Age related Osteoporosis without current fracture
- ❑ C61 Malignant Neoplasm of the Prostate
- ❑ C50. __ Breast Cancer
- ❑ Other: _____

Failed Medications: _____

Has the patient tried and failed oral bisphosphonates? If so, which ones and when? _____

Dexa Scan T Score: _____ Type: _____ Date: _____

Fracture History: Site _____ Date: _____

****Please include a demographics page, front and back of an insurance card, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis****

## Pre-Medication Orders:

- ❑ APAP □ 325mg □ 500mg □ 650mg - PO 30 minutes before infusion.
- ❑ Diphenhydramine □ 25mg □ 50mg – PO 30 minutes before infusion OR □ 25mg IVP □ 50mg IVP
- ❑ Alternate Oral Antihistamines: □ Cetirizine 10mg □ Loratadine 10mg □ Fexofenadine 60mg or □180mg
- ❑ Methylprednisolone □ 40mg IVP □ 125mg IVP or other ____ mg IVP
- ❑ Famotidine □ 20mg PO □ 40mg PO □ 20mg IVP □ 40mg IVP
- ❑ Ondansetron □ 4 mg IVP □ 4 mg PO

## Allergies: _____

## Medication

**Denosumab (Any denosumab biosimilar to be used based on payer guidelines / availability)**

**Dosage / Frequency:**

- ☑ **Denosumab 60mg SQ every 6 months in the upper arm, abdomen, or upper thigh**
- ☑ **Calcium level must be collected by prescriber for initial treatment and faxed to RSI**
- ☑ **Prescriber is responsible for clinical lab monitoring**
- ☑ **Refills x 12 months unless otherwise ordered here _____**

## Nursing

☑ **Provide nursing care per RSI Nursing Procedures, including reaction management and post-procedure observation**

## Physician Prescription Orders

Address: _____ Phone: _____ Fax: _____

Clinic Contact: _____ Physician Name: _____

***NPI #_____ Physician Signature:*** _____ ***Date:*** _____