OSTEOPOROSIS THERAPY ORDER FORM

P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

Diagnosis:

- ☐ Osteoporosis
- ☐ Paget's disease of bone
- ☐ Glucocorticoid-induced osteoporosis
- ☐ Disorder of bone (osteopenia)
- ☐ Other: _____

ICD-10 code: _____

THERAPY ORDER

Zoledronic Acid

- ☐ Zoledronic Acid 5mg/100mL IV x 1 dose

Prolia

- ☐ Prolia 60mg subcutaneous injection every 6 months x 1 year

Evenity

- ☐ Evenity 210mg subcutaneous injection once monthly x 12 doses

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____