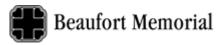


Outpatient "PROLIA" Treatment Order Note: Order valid for a maximum of twelve (12) months *Order must be completed in full*

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: Ye	es No Not Known	
Prior osteoporosis therapy: ☐Generic alendronate ☐Fosa	amax (alendronate sodium) □Actonel	(risedronate sodium)
□Boniva (ibandronate sodium)	□none □other (specify)	
Instruct patient:		
 Take over-the-counter oral calci at least 400 IU daily. 	um supplement at least 1000 mg daily	and over-the-counter oral vitamin D supplement
 Advise patient to maintain good procedures that they are receiving 		olia. Patient to inform their dentist prior to dental
Notify MD if she becomes pregn	nant while on Prolia therapy.	
Nursing Orders		
✓ Hypersensitivity/ Anaphylaxis	Management for Infusions / Desensitiz	zation - Adult Order Set
Medication Orders		
□ Denosumab (Prolia) 60 mg e	very 6 months x 1 dose	
□ Denosumab (Prolia) 60 mg e	very 6 months x 2 doses	
	nay be removed from the refrigerator a in the original container. Do not warm l	
•Administer as a subcutaneous	injection in the upper arm, upper thigh	, or abdomen
MD Print name:	Address:	
Phone #:	Fax#:	
MD Signature:	DATE:	TIME:
		Patient Sticker



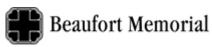
PROLIA PACKET SUBMISSION

- ➤ 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 Pro	ia injection(s), the following must be submitted:			
☐ Outpatient Prolia treatment order must be co code, provider name, provider signature, date, a	mpleted in full including diagnosis description, ICD 10 diagnosis and time.			
☐ Completed Prolia insurance verification form and copy of insurance cards, if possible.				
\square Response from Prolia insurance verification	form			
\square Office notes (within 12 months of injection) w	rith documentation from the provider as to:			
\square Why the provider wants the patient of	n Prolia.			
☐ What medications has the patient trie fracture or high risk of fracture.	ed prior to Prolia? If none, documentation must show history of			
\Box Documentation must support that the	e 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 packet at that time. Your office will be notified prior	to the second injection, you will need to provide a new to that appointment.			
For internal use only				
•				
 □ Approved 1 injection to schedule. □ Approved 2 injections to schedule (2nd in six months from □ Denied: missing: 	n first injection), documentation and DEXA scan meet the time frame.			
	Patient Sticker			



Patient Sticker		



Patient Information ☐ New Patient to Prolia ☐ Existing Patient	Physician Information			
*Patient Name:	*Physician Name:			
☐ Attach patient demographic sheet OR complete information below:	*NPI #: Tax ID #:			
*Street Address:	Specialty:			
*City:*ZIP:*	*Enter Site ID: OR Complete information below			
Phone:	*Site NPI #: Site Tax ID #:			
☐M ☐F *Date of Birth:	*Site Name:			
Fulfillment Method (Select only ONE)	*Street Address:			
□Medical Benefit (Physician Purchase)	*City: *State: *ZIP:			
□Pharmacy Benefit □Out of Network Benefits	*Phone:Fax:			
□Referral to treating site:	Office Contact:			
*Enter Site ID: OR Complete information below	*Site Type: □MD Office □Hospital Outpatient			
*Site Name:	Patient Medical Information [†]			
*Street Address:	☐M81.0 (Age-related osteoporosis without current pathological fracture)			
*City:*State:*ZIP:	☐M80.0 (Age related osteoporosis with current pathological			
*Phone:*Fax:	Fracture) Please provide complete code.			
Office Contact:	□Other (Specify ICD Code)			
*Site Type: ☐MD Office ☐Hospital Outpatient	Please provide secondary ICD Code, if applicable:			
Primary Insurance Information	Please NOTE: clinical notes and additional documentation are NOT required			
☐Attach a copy of insurance card, front AND back OR provide:	for us to process a patient benefit verification. Review of clinical			
*Insurance Name:	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.			
*Insurance Phone:				
Subscriber Name:	[†] The sample diagnosis codes are informational and not intended to be			
Subscriber Date of Birth:	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.			
Group #:				
*Policy Number #:				
Medicare Beneficiary Identifier:				
Secondary Insurance Information (if applicable)	Prescription Information			
☐Attach a copy of insurance card, front AND back OR provide:	Prolia [®] 60 mg pre-filled syringe, 60 mg SC every 6 months			
*Insurance Name:pp	Refill: □ x1			
*Is this a Medigap policy? □Yes □No □Not Known	Prescriber Signature: (required for legal prescription triage)			
If yes, please indicate plan letter:				
*Insurance Phone:	<u>α</u> Date:			
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 #:	Dationt Sticker			



Patient Sticker