Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Current Height: _____ Current Weight_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Related Diagnosis Code (ICD-10 code): _____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Denosumab Treatment Plan

Patient Name: _____ **Patient DOB** _____

General

☐ Diagnosis- Age-related Osteoporosis w/o fracture ICD-10 Code _M 81.0____

☐ Diagnosis- Other _____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

Denosumab

☐ *60 mg, Subcutaneous, Injection,* ***Day of Treatment for 1 dose***
Comments: Administer injection in upper arm, upper thigh, or abdomen

☑ *60 mg, Subcutaneous, Injection,* ***Day of Treatment for 2 doses 6 months apart***
Comments: Administer injection in upper arm, upper thigh, or abdomen

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

☑ Communication Order (Month 1 to 12)
Nursing to verify with patient that no invasive dental procedures are planned or have been recently performed. If patient answers yes, nursing to contact provider prior to proceeding with injection.

☑ Communication Order (Month 1 to 12)
Nursing to check vital signs prior to and following administration as well as monitor patient for 15 minutes after injection.

☑ Communication Order (Month 1 to 12)
Nursing to ensure negative HCQ urine screening completed prior to each infusion for females 11-55 years of age with no history of hysterectomy or bilaterial oophorectomy

☑ Communication Order (Month 1 to 12)
Nursing to verify patient has calcium level within the last 45 days prior to treatment initiation and within 6 months of subsequent injections. Nursing to notify provider if corrected calcium level returns less than 8.4mg/dL.

Labs (Month 1 to 12) Duration: 12 Months

☑ Calcium Level (if needed)

☑ HCG Pregnancy Screening- Urine (If Needed)

Attestation

Required Patient Counseling: Ordering provider has counseled patient on associated risks of medication including but not limited to osteonecrosis of the jaw, importance of regular dental exams, good oral hygiene, appropriate intake and/or supplementation of Vitamin D / Calcium and supplied patient with appropriate medication guide.

Provider initials_____ (required)

☐ Biosimilar Substitution **NOT** permitted

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Time _____