BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

OSTEOPOROSIS THERAPY ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

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

ICD-10 code : _____

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

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

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: _____ Signature: _____ Date: _____

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

☐ Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

BIOCARE INFUSION
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COMPREHENSIVE SUPPORT FOR OSTEOPOROSIS THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's current medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to other therapy

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., oral and/or IV biphosphonate)? ☐ Yes ☐ No
  If yes, which drug(s)? _____
- ☐ Please indicate prior drug therapies: ☐ Boniva ☐ Forteo ☐ Reclast ☐ Prolia ☐ Actonel ☐ Evista ☐ Fosamax ☐ Other: _____
- ☐ Does the patient have a history of a minimal trauma fracture? ☐ Yes ☐ No
  If yes, location(s)? _____
- ☐ Patient is currently taking calcium/vitamin D supplementation ☐ Yes ☐ No
- ☐ Does the patient have a FRAX 10-year fracture probability of a major osteoporotic fracture at 20% or more OR a hip fracture at 3% or more? ☐ Yes ☐
- ☐ **Pre-treatment** t-score: _____ (Osteoporosis: -2.5 or worse, Osteopenia: -1.0 or worse)
- ☐ Include labs and/or test results to support diagnosi
- ☐ Other medical necessity: _____

REQUIRED INFORMATION

☐ **Serum calcium within 6 months (required for all therapies) - attach result**

☐ **Serum creatinine within 60 days (for Zoledronic Acid) - attach result**

☐ **Serum alkaline phosphatase (Paget's diagnosis) - attach results**

☐ **DEXA Scan (osteo) - attach**

☐ **CT scan/Xray (Paget's diagnosis) - attach**

☐ **Tried and failed therapies**

Biocare Infusion willcomplete 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 refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance