

# Prolia, Jubbonti (denosumab)

Provider Order Form rev. 1/2/2025



## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Gender:  M  F  Other

Email Address: \_\_\_\_\_ Address: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height (in): \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_ Existing prior authorization?  Yes, (Send a copy)  No (AIC will process)

Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

Patient Preferred Location: \_\_\_\_\_

## DIAGNOSIS & CLINICAL INFORMATION

### ICD 10-Code & Description (Provide full completed code)

M81.0 (Age-related osteoporosis without current pathological fracture)  
 M81.8 (Other osteoporosis without current pathological fracture)  
 M80.0 (Age-related osteoporosis with current pathological fracture)

Z87.310 Personal history of healed osteoporosis fracture  
 Z79.52 (Long-term [current] use of systemic steroids)  
 Other: \_\_\_\_\_

**REQUIRED DOCUMENTATION:** Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results ( CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

## PRESCRIPTION INFORMATION

**Nursing:** Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

### Pre-Medications

Acetaminophen (Tylenol)  500mg  650mg  1000mgPO  
 Cetirizine (Zyrtec) 10mgPO  
 Loratadine (Claritin) 10mgPO  
 Diphenhydramine (Benadryl)  25mg  50mg  PO  IV  
 Methylprednisolone (Solu-Medrol)  40mg  125mg IV  
 Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

### Lab Orders

*Required:*  
Dexa Scan Results / FRAX Score  
Serum Creatinine and Serum Calcium Level  
Documentation of Oral Hygiene  
 Other: \_\_\_\_\_

**Prolia (denosumab)** (Select one):

Infuse 60 mg SubQ injection every 6 months.

**Jubbonti (denosumab-bbdz)** (Select one):

Infuse 60 mg SubQ injection every 6 months.

**Refills:**  zero  6 months  12 months  \_\_\_\_\_ (Prescription valid for one year, unless otherwise indicated)

**Post Treatment Observations:** The patient is required to stay for 30 minutes following the first administration.

**Special Instructions:** \_\_\_\_\_

## PROVIDER INFORMATION

Provider Full Name: \_\_\_\_\_ Provider NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Provider Name (Print)

Provider Signature

Date

[E: Referrals@americaninfusioncare.com](mailto:Referrals@americaninfusioncare.com)

[Americaninfusioncare.com](http://Americaninfusioncare.com)

Greater Houston Area F: 832.510.7824 P: 832.800.3213

McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454

Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213

Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454