

Patient Information

First Name, Last Name:	Date of Birth:	Gender: ☐ M ☐ F
Address:	City, State, Zip:	
Phone: ☐ Cell	SSN#	
☐ Allergies	Weight: lbs or kgs	

Prescribing Physician Information

Referring Practice:	
Practice Address:	City, State, Zip:
Prescriber Name:	Prescriber NPI:
Nurse/Key Contact:	Phone:
Fax:	Email:
Treatment Location: Choose One	☐ Location Nearest Patient's Address:

Insurance & Required Documentation *Please attach insurance card, front and back*

☐ Patient demographics ☐ Labs/tests supporting diagnosis ☐ Office/progress notes

Diagnosis *Provider must specify*

☐ Osteoporosis with pathological fracture - ICD-10: M80.

☐ Osteoporosis without pathological fracture - ICD-10: M81.

☐ If M80. Location of previous fracture:

Product Selection

☐ Prolia (denosumab) ☐ Conexence (denosumab-bnht) ☐ Stoboclo (denosumab-bmwo)

☐ Jubbonti (denosumab-bbdz) ☐ Dispense As Written (DAW)

Unless DAW is selected, product may be substituted based on insurance requirements and availability.

Pre-Medications *Not typically indicated*

☐ Acetaminophen 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone 125 mg IVP

☐ Diphenhydramine 25 mg PO ☐ Cetirizine 10 mg PO ☐ Other:

Primary Medication Order

MEDICATION	DOSE	ROUTE	FREQUENCY	Number of Refills
Denosumab	60 mg	Subcutaneous injection	Every 6 months	

Last Prolia Injection Date(If Applicable)

Labs / Special Instructions *Please include frequency*

Authorization & Signature

I authorize Infuse One and its clinical representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Infuse One.

Provider Phone Line:
833-881-6048

Please be sure to attach all of the following:

- Patient demographics
- Patient medical insurance card copied front and back
- Patient pharmacy card copied front and back (if they have one)
- Most recent chart notes, diagnostic testings, and labs.
- Proof of patient being concurrently treated with any other biologics

Physician Signature: _____
Date: _____