



Osteoporosis Referral Form

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PATIENT INFORMATION

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____ Ht: _____ Wt: _____

Please Attach: ☐ Insurance cards ☐ History & Physical ☐ Most recent labs ☐ Medication list

☐ NKDA ☐ Allergies: _____

PRESCRIBER INFORMATION

Ordering Provider Name: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ ZIP: _____

REQUIRED INFORMATION FOR EITHER PROLIA, EVENITY AND RECLAST

Documentation:

- ☐ Recent clinical office visit notes
- ☐ DEXA Report (within 2 years)
- ☐ CMP- Calcium level lab results (within 6 months)

Tried and Failed Medications:

- ☐ Fosamax ☐ Evista ☐ Boniva
- ☐ Actonel ☐ Reclast ☐ Contraindications to above: _____

MEDICATION ORDERS

ICD-10 Diagnosis Codes:

☐ Evenity ☒ M81.0 ☐ M81.8 ☐ Other _____

☐ Reclast ☒ M81.0 ☐ M81.8 ☐ Other _____

☐ Prolia ☒ M81.0 ☐ M81.8 ☐ Other _____

☐ New to Therapy ☐ Continuation of Therapy: Date of last dose (if applicable): _____

DOSING/FREQUENCY:

☐ Evenity 210mg (two 105mg prefilled syringes) subcutaneous once a month for 12 doses

☐ Reclast 5mg/100ml IV infusion over at least 15 minutes once annually. **Most recent weight** _____

☐ Prolia 60mg/ml subcutaneous injection every 6 months

(substitution with Denosumab biosimilar may be made according to insurance plan requirements)

☐ Refills: _____

Sage Infusion Standing Orders:

- ☒ Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name

Provider Signature

Date