



Denosumab Biosimilars

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes.
Trinity Health will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: \_\_\_\_\_

Referral Status: [ ] New Referral [ ] Dose or Frequency Change [ ] Renewal

Patient Name: \_\_\_\_\_
Date of Birth: \_\_\_\_\_
Weight: \_\_\_\_kg Height: \_\_\_\_cm
Allergies: \_\_\_\_\_
Primary Insurance: \_\_\_\_\_
Member ID: \_\_\_\_\_
Secondary Insurance: \_\_\_\_\_
Member ID: \_\_\_\_\_

Diagnosis
Diagnosis Code (ICD-10): [ ] M81.0 [ ] Other \_\_\_\_\_
Indication: \_\_\_\_\_
Target start date: \_\_\_\_\_
Labs
[ ] Calcium
[ ] Albumin
[ ] Other: \_\_\_\_\_
(Calcium/albumin required within 30 days of treatment)

NOTE TO PROVIDER: All patients with Denosumab (PROLIA®) prescribed should receive at least 1000 mg Calcium and 400 IU Vitamin D daily per prescribing information (note: Calcium is best absorbed if doses greater than 500 mg are divided).

Hold and notify provider: Notify provider and hold at provider discretion for Ca <7 mg/dL. Calcium level should be corrected prior to initiation of treatment.

Pre-medications:

No routine pre-medications are given. Pre-medications may be ordered at physician discretion.

[ ] Other: \_\_\_\_\_

Denosumab Biosimilar - subcutaneous injection every 6 months

- [ ] Pharmacist to select \*
[ ] Conexence (denosumab-bnht) - preferred
[ ] Stoboclo (denosumab-bmwo)
[ ] Jubbonti (denosumab-bbdz)
[ ] Prolia (denosumab)

\*Pharmacist will work with financial coordinator to select product based on patient's insurance coverage & Trinity Health Formulary in the following order Conexence -> Stoboclo -> Jubbonti -> Prolia

Nursing Orders:

Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary:

sodium chloride 0.9% bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN; meperidine injection 25 mg PRN

Provider Name: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Office Fax Number: \_\_\_\_\_

Attending Physician Name: \_\_\_\_\_

(If ordering provider is an advanced practice practitioner)

Note: This order is valid for 12 months from date of physician signature.