FLEXCARE INFUSION CENTERS

Fax: (888) 219-8102 | **Email:** orders@flexcareinfusion.com | **Visit:** flexcareinfusion.com/referrals

OSTEOPOROSIS REFERRAL FORM

PATIENT DEMOGRAPHICS:

PATIENT NAME: Alice Smith	PATIENT'S CONTACT #: 212-123-4567
DATE OF REFERRAL: 02/28/2022	ADDRESS: 195 Montague St
DATE OF BIRTH: 12/31/1994	CITY, STATE, ZIP: Brooklyn, NY 11201
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN: 1234	
HEIGHT: 5 FEET 8 INCHES	GENDER: FEMALE ☑ MALE ☐
WEIGHT: 165 LB or _____ KG	ALLERGIES: SEE LIST ☐ NKDA ☑

PRIMARY DIAGNOSIS:

☐ M81.0 - Age-related osteoporosis without current pathological fracture ☐ M80.00XS - Age-related osteoporosis with current pathological fracture, unspecified, sequela

☑ M80.00XA - Age-related osteoporosis with current pathological fracture, unspecified site, initial encounter for fracture

☐ Other

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

☑ 1. INSURANCE CARD (Front & Back) ☑ 2. PATIENT DEMOGRAPHICS ☑ 3. MOST RECENT LABS ☑ 4. MEDICATION LIST
☑ 5. H & P ☑ 6. TRIED/FAILED THERAPIES ☑ 7. DEXA SCAN ☑ 8. CURRENT CALCIUM LEVELS

PRIMARY MEDICATION ORDER:

Please include MEDICATION, DOSE, FREQUENCY, DURATION and any ADDITIONAL administration INSTRUCTIONS specific to the primary therapy.

☐ Prolia 60 mg subcutaneous injection every 6 months.

☑ Evenity 210 mg subcutaneous injection every month for 12 doses.

☐ Zoledronic Acid 5 mg IV once yearly.

☐ Other:

☑ Labs to be drawn with each infusion/injection:

FIRST DOSE: ☐ Y ☐ N

☑ Refill x12 months unless otherwise noted.

PRN & PREMEDICATIONS:

MEDICATIONS	30 minutes prior to every infusion/ injection	PRN
Acetaminophen 650 mg PO	☐	PRN every ___ hour for mild or moderate infusion/ injection reaction.
Diphenhydramine 25 mg PO	☑	PRN every ___ hour for mild or moderate infusion/ injection reaction.
Diphenhydramine 25 mg IV	☐	PRN every ___ hour for mild or moderate infusion/ injection reaction.
Methylprednisolone 125 mg IV	☐	PRN every ___ hour for mild or moderate infusion/ injection reaction.
Other: _____	☐	PRN every ___ hour for mild or moderate infusion/ injection reaction.

LINE USE/CARE ORDERS:

☑ START PIV/ACCESS CVC

☑ FLUSH DEVICE PER FLEXCARE INFUSION POLICY & PROCEDURE (SEE REVERSE SIDE)

☐ OTHER FLUSH ORDERS: (please fax other reaction orders if checking this box)

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

☑ ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side)

☐ OTHER: (please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION: Please check preferred form of communication.

PROVIDER NAME: Provider X	PHONE: 212-123-4567
OFFICE CONTACT: Bob Doe	☐ FAX: 212-987-6543
ADDRESS: 1 1st Ave	☐ EMAIL: foo@gmail.com
CITY, STATE, ZIP: New York, NY 10000	NPI:

→ (GENERIC SUBSTITUTION PERMITTED)
PROVIDER SIGNATURE:

DATE:

→ (DISPENSE AS WRITTEN)
PROVIDER SIGNATURE:

DATE: