Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Denosumab or Biosimilar Injection Order (Revised 11/11/2025)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:

Allergies: (please list all allergies or attach list)

☐ NKDA

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

☐ M81.0 - Age-related osteoporosis without current fractures ☐ Other:

☐ M80.0____ - Age-related osteoporosis with current pathological fracture

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Labs:

☑ Urine Pregnancy Test for all females of reproductive potential every 26 weeks
- POC HCG Qualitative, Urine

Treatment Parameters:

☑ Required Lab Results: (**Fax labs with order**)
- Calcium and Creatinine within 3 months PRIOR to treatment.

☑ Hold Treatment and Notify Provider IF:
- Serum calcium or corrected calcium is LESS THAN 8.6mg/dL, or the result is unavailable;
- Urine pregnancy is unavailable or POSITIVE for all females of reproductive potential;
- Creatinine clearance is LESS THAN 30mL/min.

Provider Communication:

Required PRIOR to treatment:

☑ In patients with advanced chronic kidney disease, including dialysis-dependent patients, evaluate for presence of chronic kidney disease mineral and bone disorder with intact parathyroid hormone, serum calcium, 25(OH) vitamin D, and 1,25 (OH)2 vitamin D prior to decisions regarding denosumab. Consider also assessing bone turnover status to evaluate underlying bone disease that may be present.

Nursing Communication:

☑ Obtain vital signs PRE-treatment. Obtain vital signs POST-treatment PRN.

☑ Remind patients to take calcium and vitamin D as prescribed by their provider.

☑ Monitor for any signs of reaction for 30 minutes AFTER 1st treatment and subsequent treatments PRN if previous signs of reaction observed.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)

☐ Acetaminophen (Tylenol) 650mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg PO ONCE

☐ Loratadine (Claritin) 10mg PO ONCE

Infusion Therapy:

☑ Denosumab or biosimilar 60mg SC injection every 26 weeks

Atrium Health will authorize the payer preferred denosumab product

☑ **Please list any contraindicated denosumab product:**

Please list the reason for the contraindication:

Supportive Care Medications:

☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.

☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.

☑ Ondansetron (Zofran) 4mg PO ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:

Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: