

XGEVA (DENOSUMAB) ORDER FORM

Preferred Brand: _____

Dispense As Written (DAW) Will substitute for biosimilar or reference product based on insurance and availability

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____ kg

Allergies: _____

New Start Therapy | Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

Hypercalcemia, ICD 10: E83.52 Multiple myeloma, ICD 10: C90. _____

Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO Famotidine 20 mg IV Methylprednisolone (Solu-Medrol) 125 mg IVP

Benadryl 25mg PO Cetirizine (Zyrtec) 10 mg PO

Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Xgeva	120 mg	Subcutaneous Inj	<input type="checkbox"/> Every 4 months <input type="checkbox"/> Other: _____

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:

CT: 203.433.0621
 FL: 904.877.9270

MA: 413.296.8482
 MD: 240.224.8607
 ME: 207.407.7272

NC: 919.984.8698
 NH: 603.217.5371
 NJ: 201.581.4521

NY: 631.250.6020
 OH: 937.871.4594
 PA: 610.273.5998

SC: 864.973.6279
 VA: 703.202.0499