

## XGEVA (DENOSUMAB) ORDER FORM

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

### 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

Benadryl 25mg PO  Cetirizine (Zyrtec) 10 mg PO (Solu-Medrol) 125 mg IVP

Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

### MEDICATION

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

New Start Therapy  Continuation of Therapy Date of last dose (if applicable): \_\_\_\_\_

### LABS / SPECIAL INSTRUCTIONS

**FAX NUMBERS:**  CT: 203.433.0621  ME: 207.407.7272  NH: 603.217.5371  NJ: 201.581.4521

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