

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

INFUSION ORDERS – XGEVA (DENOSUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:
REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal	
DIAGNOSIS AND ICDE 10 CODE	
<input type="checkbox"/> Bone Metastases from Solid Tumor	ICD 10 Code: C79.51
<input type="checkbox"/> Multiple Myeloma with Bone Involvement	ICD 10 Code: C90.00
<input type="checkbox"/> Giant Cell Tumor of Bone	ICD 10 Code: D48.0
<input type="checkbox"/> Hypercalcemia of Malignancy	ICD 10 Code: E83.52
<input type="checkbox"/> Primary Cancer Site:	ICD 10 Code:
Is patient currently taking required Calcium and Vitamin D Supplementation <input type="checkbox"/> Yes <input type="checkbox"/> No <i>MANDATORY: All patients must receive adequate calcium and vitamin D supplementation unless hypercalcemia is present.</i>	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)	
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number <input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Image studies confirming bone metastases (if applicable)	<input type="checkbox"/> Calcium level (within 30 days) <input type="checkbox"/> Creatinine and renal function <input type="checkbox"/> Pathology report confirming primary cancer diagnosis <input type="checkbox"/> DEXA Scan results and/or FRAX score (must be within 2 years) <i>*Patients with creatinine clearance <30 mL/min or on dialysis are at greater risk for hypocalcemia</i>
List of tried and failed therapies, including duration of treatment: _____	
MEDICATION ORDERS	
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ Current Calcium Level: _____	
Bone Metastases from solid	<input type="checkbox"/> J0897 Xgeva 120 mg SubQ every 4 weeks <input type="checkbox"/> J0897 Xgeva 120 mg SubQ every _____ weeks
Multiple Myeloma	<input type="checkbox"/> J0897 Xgeva 120 mg SubQ every 4 weeks <input type="checkbox"/> J0897 Xgeva 120 mg SubQ every _____ weeks
Giant cell tumor of bone	<input type="checkbox"/> J0897 Xgeva 120 mg SubQ on Days 1, 8, and 15 of first month <input type="checkbox"/> J0897 Xgeva 120 mg SubQ every 4 weeks (beginning month 2) <input type="checkbox"/> J0897 Xgeva 120 mg SubQ every _____ weeks
Hypercalcemia of malignancy	<input type="checkbox"/> J0897 Xgeva 120 mg SubQ on Days 1, 8, and 15 of first month <input type="checkbox"/> J0897 Xgeva 120 mg SubQ every 4 weeks (beginning month 2) <input type="checkbox"/> J0897 Xgeva 120mg SubQ every _____ weeks
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses	
LAB ORDERS	
<input type="checkbox"/> CBC Frequency: _____ <input type="checkbox"/> CMP Frequency: _____ <input type="checkbox"/> Serum Calcium <input type="checkbox"/> Prior to each dose or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Serum Phosphorus Frequency: _____ <input type="checkbox"/> Serum Magnesium Frequency: _____	
ADDITIONAL ORDERS/INFORMATION	

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PRESCRIBER INFORMATION		
Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

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