

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____
Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):
Primary Diagnosis: _____ Hypercalcemia of Malignancy ICD-10 Code: E83.52 _____
_____ Giant Cell Tumor of Bone ICD-10 Code: M27.1 _____
_____ Other: _____ ICD-10 Code: _____
Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:
• Clinical MD Notes, labs, test supporting primary diagnosis
• Documentation of therapies previously trialed and failed
• DEXA Scan Results indicating osteoporosis
• Recent serum calcium
• Current medication list:
◦ Patient is currently receiving calcium/vitamin D supplementation:
 Yes No Other: _____

Patient
Weight: _____ lbs.
Height: _____ in.

XGEVA® (denosumab) J Code: J0897

4. Drug Order:
Xgeva (denosumab): 120 mg administered subcutaneously _____ # Refills (Recommend 6)
 New Patient
Administer on week 0, week 1, week 2, week 4 and then every 4 weeks thereafter
 Ongoing Patient
Administer every four weeks

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ **Date:** _____
Dispense as written Substitution permitted
Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION
CENTRAL FAX 803.999.1754
ALTERNATE FAX 803.999.1887

INFUSION CENTER LOCATIONS
COLUMBIA CHARLESTON GREENVILLE
CENTRAL INTAKE PHONE 803.999.1960