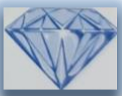

AYSA
THERAPEUTICS INFUSION

OSTEOPOROSIS ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: ______________________ DOB: ______________ Phone: ______________________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: ☐ Senile Osteoporosis ____________________ ☐ Paget's disease of bone ______________________

☐ Glucocorticoid-induced osteoporosis ______________________

Patient Weight: ___________ lbs. Allergies: ____

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

☐ Dexa Scan (-2.5 T score or more severe) ***if no -2.5 T score, please send history of fracture documentation*

☐ Labs: Prolia - Calcium within 6 months, CrCl if CKD;ZA - CMP/BMP within 60 days, Evenity - Calcium within 6 months

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: ____

Tried & Failed Medications:

☐ Fosamax: Duration: ____________ Reason for Discontinuing: ______________________________

☐ Boniva: Duration: ____________ Reason for Discontinuing: ______________________________

☐ Actonel: Duration: ____________ Reason for Discontinuing: ______________________________

☐ Evista: Duration: ____________ Reason for Discontinuing: ______________________________

☐ Prolia: Duration: ____________ Reason for Discontinuing: ______________________________

ZOLEDRONIC ACID

J Code: J3489 Patient Weight: ________ lbs.

*Patient is currently taking calcium/vitamin D supplementation ☐ YES ☐ NO ☐ Other

☐ Zoledronic Acid 5mg/100mL IV once yearly

PROLIA SUB Q

J Code: J0897 Patient Weight: ________ lbs.

*Patient is currently taking calcium/vitamin D supplementation ☐ YES ☐ NO ☐ Other

☐ Prolia 60mg subcutaneous injection every 6 months *Date of last Prolia injection: ________________

EVENITY SUB Q

J Code: J3111 Patient Weight: ________ lbs.

*Patient is currently taking calcium/vitamin D supplementation ☐ YES ☐ NO ☐ Other

☐ Evenity 210mg subcutaneous injection once monthly

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc*., and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ______________________ Physician Name: ______________________ Date: __________

Phone: ____________________ Fax: ____________________ Contact Person: ________________________

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