Prolia/Reclast/Evenity Referral Form

FAX TO: 615-986-4381

TENNESSEEONCOLOGY
a partner of OneOncology

Patient Name: _____ **Date of Birth:** _____/_____/_____ **Weight:** _____
Patient Phone: _____ **Date of Referral:** _____/_____/_____
Referring Provider: _____ **MD Phone:**_____ **MD Fax:**_____
Preferred Clinic Location: _____ **Preferred Provider:** _____

Records Required for Referral:

1. **Attach** most recent **DEXA** scan results **(must be within the last 2 years).** Date of Scan: _____/_____/_____
   T-Score: _____
2. **Attach** most recent **CMP/BMP (must be within 4-6 weeks of referral).** Date of Labs: _____/_____/_____
   Note: *Ref Range for Serum Ca: 8.6 - 10.2mg/dl * **Serum Ca:** _____
3. **Attach** most recent **office note**. Date of Office Visit: _____/____/_____

Diagnosis with correlating ICD-10 code: _____

Please check the appropriate use case listed below, and complete ALL required fields:

PROLIA (Denosumab) 60mg SQ every 180 days	RECLAST (Zoledronic acid) 5mg IV every 365 days	EVENITY (Romosozumab-aqqg) 210mg SQ every 28 days
❑ Treatment of Postmenopausal women with osteoporosis at high risk for fracture ❑ Treatment to increase bone mass in men with osteoporosis at high risk for fracture. ❑ Treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer. ❑ Treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer.	❑ Treatment and prevention of postmenopausal osteoporosis ❑ Treatment to increase bone mass in men with osteoporosis ❑ Treatment and prevention of glucocorticoid induced osteoporosis ❑ Treatment of Paget's Disease of bone in men and women **Serum Creatinine:** _____ **Creatinine Clearance:** _____ **Note: *CrCl must be >35ml/min***	❑ Treatment of osteoporosis in postmenopausal women at high risk of fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture, or patients who failed or are intolerant of other available therapy.

My signature authorizes administration of the medication selected. I understand that TN Oncology may change the selected medication to another listed medication on this document if required by the patient's insurance.
*****This order is valid for 12 months from the date of the patient's first scheduled treatment.*****

Previous Treatment		
Any previous oral/IV bisphosphonate treatment? YES / NO		
Reason for Failure: (circle) **Intolerant/ GI/PPI Failure /** Other: _____	**Agent Name:**_____**PO/IV**	**Is this continuation of care? Y / N**
Fracture History		
Does the patient have a history of osteoporotic fracture? YES / NO	**Date:** _____/_____/_____ **Fracture site:** _____	***Radiology reports of previous osteoporotic fracture(s) are required for referral. (X-Ray/MRI/CT)***

*******I understand that any missing records required for referral could delay processing of this referral. *******

Referring Provider Signature: _____ **Date:** _____/_____/_____