

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

Allergies: \_\_\_\_\_ Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

**Financial authorizations require clinical documentation of medical necessity. To ensure compliance, the criteria below must be indicated as completed by office representative. Incomplete documentation will be returned to the referring office for completion, resulting in delays to the patient receiving treatment.**

- Ordering provider is credentialed at Sinai Hospital (Alvin and Lois Lapidus Cancer Center) or Carroll Hospital (William E. Kahlert Regional Cancer Center) to admit and write orders.
- Demographics / insurance information attached, or available in Cerner.
- Provider note dated within 30 days indicating medical need attached, or date if available in Cerner: \_\_\_\_\_
- Patients on antiresorptive therapy should have bone densitometry / DEXA scan repeated every 2 years. Most recent dexa scan results attached, or available in Cerner. Date of most recent dexa scan if available in Cerner: \_\_\_\_\_
- Calcium level must be ordered, completed and results available within 30 days prior to the administration of denosumab. Lab results attached, or available in Cerner. Date if available in Cerner: \_\_\_\_\_

Does the patient have any dental concerns that would prohibit receiving denosumab?  No  Yes

If yes, explain: \_\_\_\_\_

List the date of last dose of previously prescribed antiresorptive therapy below:

Name of therapy: \_\_\_\_\_ Date last administered: \_\_\_\_\_

- Not previously on antiresorptive therapy

**NOTE:**

- ***Prolia® and its biosimilars are not for use in patients already receiving Reclast®, Zometa®, other bisphosphonates, or denosumab products including Xgeva®, or biosimilars***
- ***Pre-existing hypocalcemia and vitamin D deficiency should be corrected prior to initiation of therapy. Calcium and vitamin D supplementation is recommended throughout the duration of therapy with zoledronic acid.***

**Treatment:**

**\*\*\*Unless dictated by insurance, Denosumab-bbdz (Jubbonti®) will be the biosimilar / product of choice.\*\*\***

- Denosumab-xxxx 60 mg subcutaneously every 6 months

**Protocol Orders:**

- Hypersensitivity/Anaphylaxis Medications: Follow Adult Hypersensitivity Nursing Protocol PRN for the treatment of allergic / hypersensitivity reaction.

Provider's Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**ALVIN & LOIS LAPIDUS CANCER CENTER  
(SINAI HOSPITAL)**  
FAX: 410-601-4452  
PHONE: 410-601-4779

**Wm. E. KAHLERT CANCER CENTER  
(CARROLL HOSPITAL)**  
FAX: 410-871-6521  
PHONE: 410-871-6400