Trinity Health Muskegon & Shelby Infusion Clinics
Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444
Shelby: 72 S. State St. Shelby, MI 49455
Fax (shared): 231-727-4328

Denosumab 120mg Biosimilars

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____ **Site of Service:** ☐ TH Muskegon ☐ TH Shelby

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ **Date of Birth**: ____/____/____ **Weight:** _____kg **Height:** _____cm **Allergies:** _____	**Primary Insurance:** _____ **Member ID:** _____ **Secondary Insurance:** _____ **Member ID:** _____

Diagnosis

Diagnosis Code (**ICD-10**): _____
Indication: _____
Target start date: _____

Labs

☐ Albumin
☐ Magnesium
☐ Creatinine (serum)
☐ Calcium
☐ Other: _____

☐ Once
☐ Monthly
☐ Prior to each inj
☐ Other: _____

NOTE TO PROVIDER: All patients with Denosumab (biosimilars) prescribed should receive at least 1000 mg Calcium and 400 IU Vitamin D daily per prescribing information. (note: Calcium is best absorbed if doses greater than 500 mg are divided).

Hold and notify physician:
Notify provider and hold at provider discretion for Ca < 7 mg/dL or Magnesium < 1.5 mg/dL. Calcium and magnesium level should be corrected prior to initiation of treatment.

Pre-medications:
No routine pre-medications are given. Pre-medications may be ordered at physician discretion.
☐ Other: _____

Denosumab 120 mg subcutaneous injection Frequency: _____

☐ Pharmacist to select *
☐ Bomyntra (denosumab-bnht) – *preferred*
☐ Osenvelt (denosumab-bmwo)
☐ Wyost (denosumab-bbdz)
☐ Xgeva (denosumab)

*Pharmacist will work with financial coordinator to select product based on patient's insurance coverage & Trinity Health Formulary in the following order Bomyntra → Osenvelt → Wyost → Xgeva

Nursing Orders:
Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary: sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN

Provider Name: _____ Provider Signature: _____
Office Phone Number: _____ Office Fax Number: _____
Attending Physician Name: _____
(If ordering provider is an advanced practice practitioner)

Note: This order is valid for 12 months from date of physician signature.

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