Nevada Infusion
Infusion Location (Pick one):
◯ **Reno** | ◯ **Sparks** | ◯ **Carson City** | ◯ **Las Vegas**
PH: 775-453-0667 | Fax: 775-470-8478

Denosumab Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Age-related osteoporosis without current pathological fracture (ICD-10:M81.0)
- ☐ Other osteoporosis without current pathological fracture (ICD-10 Code: M81.8)
- ☐ Age-Related Osteoporosis with current pathological fracture (ICD-10 code: M80.0_____)** Complete code**
- ☐ Other_____ ICD-10:_____

Allow Nevada Infusion to determine the Denosumab Product:

***Denosumab product as required by patient's insurance determination.
(Preferred Denosumab product to be determined after benefits investigation by intake team)**

☐ **60 mg/1 ml Subcutaneously every 6 months x 1 Year**

OR Other Dose: _____

Provider Requests Specific Denosumab Product:

☐ Jubbonti (denosumab-bbdz) ☐ Osvyrti (denosumab-desu)
☐ Prolia (denosumab) ☐ Other:_____

Dose: 60 mg/1 ml SC every 6 months x 1 YEAR

☐ Patient is currently taking Calcium/Vitamin D Supplement:
☐ Yes OR ☐ No

☐ ****DEXA Scan - please attach results****

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
☐ Other: _____

NURSING: Per Nevada Infusion
LABS ORDERS: **Order for serum calcium prior to starting injection and annually.**
Additional Lab Orders: _____
Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Revised: 11/2026

Nevada Infusion
Infusion Location (Pick one):
◯ Reno | ◯ Sparks | ◯ Carson City | ◯ Las Vegas
PH: 775-453-0667 | Fax: 775-470-8478

Jubbonti Order Form

Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed Provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

- ☐ Original Diagnostic T-Score: _____ T-Score Date: _____
- ☐ History of osteoporotic fracture
- ☐ Prior Osteoporosis Therapy (if any):
  - ☐ Generic alendronate
  - ☐ Fosamax® (alendronate sodium)
  - ☐ Actonel® (risedronate sodium)
  - ☐ Boniva® (ibandronate sodium)
  - ☐ Other _____
- ☐ Reason for Discontinuing Previous Osteoporosis Therapy(ies): _____
- ☐ Contraindications (if any): _____
- ☐ Patient is currently taking calcium and vitamin D supplements:
  - ☐ Yes OR ☐ No
- ☐ Calcium levels required (recent within last 6 months):
  - ☐ Yes OR ☐ No

Any Additional Pertinent Information: _____

Additional REQUIRED Information:

☐ Include labs and/or test results to support diagnosis

☐ Calcium, phosphorus, magnesium levels (within 6 months) - please attach results

☐ **DEXA Scan - please attach results**

☐ Other medical necessity: _____

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