



**PARAGON**  
HEALTHCARE

A Carelon Company

# OSTEOPOROSIS THERAPY ORDERS

**P: 877-365-5566 | F: 855-889-2946**

## PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Allergies:				

<b>Diagnosis Code ICD-10 (required):</b>	<b>Diagnosis Description:</b>
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Treatment Date:

## PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:		Email:	
Address:		City:	State: ZIP:
NPI #:	DEA#:	Tax ID:	

## INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

## PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
<input type="checkbox"/> <b>Denosumab OR denosumab biosimilar</b> *Preferred product TBD after benefits investigation (noted below)  <input type="checkbox"/> Do not substitute Give the following denosumab product: _____	<input type="checkbox"/> 60mg subcutaneous injection every 6 months	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
<b>Evenity</b> (romosozumab)	<input type="checkbox"/> 210mg subcutaneous injection once monthly  If osteoporosis therapy remains warranted, continued therapy with an anti-resorptive agent should be considered <ul style="list-style-type: none"> <li>• Would you like for Paragon to transition the patient to denosumab or denosumab biosimilar after 12 doses of Evenity? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul>	<input type="checkbox"/> _____ <input type="checkbox"/> x 12 doses

Other orders: \_\_\_\_\_

Lab Orders: \_\_\_\_\_ Lab frequency: \_\_\_\_\_

Required labs to be drawn by  Paragon Healthcare  Referring Provider

**For denosumab: additional pre-injection and post-injection labs are required for patients with GFR <30mLmin/1.73m<sup>2</sup>**

## \*FOR PARAGON USE ONLY

Drug/Brand Selection: \_\_\_\_\_

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.

Dispense as written

## PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

**Prescriber Signature: X**

**Date:**

**PATIENT INFORMATION**

Name:

DOB:

**REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL**

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's current medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to other therapy
  - Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., oral and/or IV bisphosphonate)?
    - Yes  No If yes, which drug(s)? \_\_\_\_\_
  - Please indicate prior drug therapies:  Boniva  Forteo  Reclast  Prolia  
 Actonel  Evista  Fosamax  Other: \_\_\_\_\_
  - Does the patient have a history of a minimal trauma fracture?  Yes  No  
If yes, location(s)? \_\_\_\_\_
  - Patient is currently taking calcium/vitamin D supplementation  Yes  No
  - Does the patient have a FRAX 10-year fracture probability of a major osteoporotic fracture at 20% or more OR a hip fracture at 3% or more?  Yes  No
  - Pre-treatment** t-score: \_\_\_\_\_ (Osteoporosis: -2.5 or worse, Osteopenia: -1.0 or worse)
- Include labs and/or test results to support diagnosis
- Other medical necessity: \_\_\_\_\_

**REQUIRED INFORMATION**

- Calcium within 6 months (required for all therapies)**
- PTH; 25(OH) Vit D; 1,25 (OH)<sub>2</sub> Vit D (Prolia patients with GFR <30mL/min/1.73m<sup>2</sup>)\***
- DEXA Scan (osteo)**
- Tried and failed therapies**