Arthritis & Osteoporosis Center, LLC

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Infusion Order

Patient name_____DOB_____

Phone number_____

Circle Diagnosis for which patient will be treated for and do required tests.

Osteoporosis (M81.0, M81.8) **DEXA, Creatinine, Calcium, Alkaline Phosphatase, and Vitamin D**

_____ Reclast (Zoledronic Acid) 5mg IV annually x 3 doses

_____ Prolia 60 mg SC every 6 months

_____ Evenity 210 mg SC every month x 12 months

Gout (M1A.09X) **G6PD and Uric Acid**

_____ Krystexxa 8 mg IV every 2 weeks

Hypercholesterolemia (E78.00) **Lipid Panel**

_____ Leqvio 284 mg SC month 0, month 3, and then every 6 months thereafter

Pre Meds given PRN Yes or No (circle one)

____Diphenhydramine 25mg/50mg (circle one) IV/PO ____ Solu-Medrol 40mg IV ____Acetaminophen 650mg PO
_____ Other or additional instructions_____
_____

Is this a new treatment for this patient_____ or continuing treatment_____

Prior tried and failed medications_____

Contact person_____ Phone_____ Fax _____

Name of ordering provider_____

Ordering provider signature_____ Date _____

Order valid for one year.

Please fax this information, required tests, last two office notes, and insurance cards to infusion coordinator at 302-613-4697. Infusion Coordinator can be reached at 302-483-7053.

Additional forms may be found on our website at ArthritisDE.com.