Androscoggin Valley Hospital

Patient Name:
DOB:
Address:
Cellphone:

AVH Infusion Center P 603-326-5782 F 603-326-5971
Monday - Friday 8am-4pm

Osteoporosis Order Sheet

Please send copy of Prior Authorization with this form, if required

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Status ☐ New Therapy ☐ Order Renewal ☐ Dosage or Frequency Change

Diagnosis
☐ ICD 10 Code: _______ Osteoporosis ☐ ICD 10 Code: _______ post-menopausal
☐ ICD 10 Code: _______ _____________ ☐ ICD 10 Code: _______ ________________

Order
☐ Prolia 60mg subcutaneous injection once every 6 months
☐ Reclast 5mg IV infusion once yearly
☐ Boniva 3mg IV push once every 3 months
☐ Evenity 210mg subcutaneous injection once monthly for 12 months

Biosimilar, generic or insurance preferred, okay? YES or NO (circle one)

Patients Height: _________________ inches

Patients Weight: _________________ lbs or kg (circle one)

Premeds
☐ No premeds necessary
☐ Other: ____
____

Labs (What and when): ____
Provide results to: _________________________________ Fax: ______________________________
☐ N/A

Other Considerations (Monitoring, rate, etc)
____
____

Ordering provider ____ **Office Number** _________________________

Provider signature _______________________________________ **Date** ______________________________

NCH provider co-signature (if required): _______________________ **Date** ______________________________

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REQUIRED DOCUMENTATION

FAX to (603)-326-5971

Clinical / Progress Notes, supporting primary diagnosis: (AVH to validate necessity of IV treatment)
- Most recent office notes pertinent to therapy being ordered, including most recent DEXA scan
- Chart Summary
- Medication/Allergy List

Most Recent **Labs**:
- Labs pertinent to therapy ordered

Prior Authorization: (when required)
- Services cannot be scheduled until a valid prior authorization is obtained by the ordering provider
- Please provide supporting documentation if authorization is not required