



Jupiter Infusion  
140 Jupiter Lakes Blvd, Suite A  
Jupiter, FL 33458  
Office: 561-277-9211

## Osteoporosis Order Form

**PATIENT INFORMATION:** Fax completed form, insurance information, and clinical documentation to 561-277-9226

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

### MEDICAL INFORMATION

Patient Weight: \_\_\_\_\_ lbs./kg. (required) Allergies: \_\_\_\_\_

#### Diagnosis:

- |  |  |
|--|--|
| <input type="checkbox"/> Osteoporosis                        | <input type="checkbox"/> Disorder of bone (osteopenia) |
| <input type="checkbox"/> Paget's disease of bone             | <input type="checkbox"/> Other: _____                  |
| <input type="checkbox"/> Glucocorticoid-induced osteoporosis |  |

ICD-10 code: \_\_\_\_\_

### THERAPY ORDER

#### Zoledronic Acid

- Zoledronic Acid 5mg/100mL IV x 1 dose

#### Prolia

- Prolia 60mg subcutaneous injection every 6 months x 1 year

#### Evenity

- Evenity 210mg subcutaneous injection once monthly x 12 doses

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Jupiter Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

### PROVIDER INFORMATION

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_