

Princeton / Somerset New Jersey
49 Veronica Avenue
Suite 202
Somerset, NJ 08873

Long Branch
422 Morris Avenue
Suite 7
Long branch, NJ 07740

Marlton
127 Church Road
Suite 600
Marlton, NJ 08053



MEDICATION ORDERS PROLIA (DENOSUMAB)

Date: _____

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

New Referral Dose or Frequency Change Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location*:

*List of infusion center locations may be found at: <https://metroinfusioncenter.com/infusion-center-locations/>

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE

- | | |
|---|-------------------|
| <input type="checkbox"/> Age related Osteoporosis without current pathological fracture | ICD10 Code: M81.0 |
| <input type="checkbox"/> Age related Osteoporosis with current pathological fracture | ICD10 Code: M80.0 |
| <input type="checkbox"/> Other Diagnosis: _____ | ICD10 Code: _____ |

REQUIRED DOCUMENTATION

- | | |
|---|--|
| <input type="checkbox"/> This signed order form by the provider | <input type="checkbox"/> Clinical/Progress notes |
| <input type="checkbox"/> Patient demographics AND insurance information | <input type="checkbox"/> Labs and Tests supporting primary diagnosis |
| <input type="checkbox"/> Serum creatinine and serum calcium level | <input type="checkbox"/> DEXA scan results and/or FRAX score |
| <input type="checkbox"/> Documentation of oral hygiene | <input type="checkbox"/> Menopause: Age _____ <input type="checkbox"/> Hysterectomy: Age _____ |

List Tried & Failed Therapies, including duration of treatment (please comment specifically on bisphosphonates):

- 1)
- 2)

MEDICATION ORDERS

Dosing	<input type="checkbox"/> Prolia 60mg SubQ every 6 months
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

PRESCRIBER INFORMATION

Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____