

- Borough Park**
1428 36th Street
Suite 107
Brooklyn, NY 11218
- Crown Heights**
555 Lefferts Avenue
Brooklyn, NY 11225
- Manhattan**
57W 57 Street
Suite 601
New York, NY 10019
- Manhasset**
333 East Shore Road
Suite 201
Manhasset, NY 11030
- Rockville Centre**
165 North Village Avenue
Suite 133
Rockville Center, NY 11570
- Elmsford/ Terrytown**
555 Taxter Road
3rd Floor
Elmsford, NY 10523
- NYC Central Park West**
115 Central Park West
Suite 15
New York, NY 10023
- Woodbury**
75 Froehlich Farm
Woodbury, NY 11797
- Staten Island**
27 New Dorp Lane
Staten Island, NY 10306



- Manhattan**
225 E 70th Street
Suite 1E
New York, NY 10021
- Queens**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375
- Manhattan**
225 East 70th Street
New York, NY 10021
- Holbrook/ Ronkonkoma**
233 Union Ave
Suite 207
Holbrook, NY 11741
- Scarsdale**
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583
- 5 Towns**
141 Washington Avenue
Cedarhurst, NY 11559
- Long Beach**
917 Beech Street
Long Beach, NY 11561
- Riverhead**
1228 E Main Street
Suite A
Riverhead, NY 11901
- Bronx**
226 West 238th Street
Bronx, NY 10463

MEDICATION ORDERS PROLIA (DENOSUMAB)

Date: _____

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> 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"/> Patient demographics AND insurance information <input type="checkbox"/> Serum creatinine and serum calcium level <input type="checkbox"/> Documentation of oral hygiene	<input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> DEXA scan results and/or FRAX score <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 _____