

Vermont  
28 Park Ave  
Suite #1A  
Williston, VT 05495



# 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
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## INFUSION OFFICE PREFERENCES (Optional)

Preferred Location*:
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\*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 \_\_\_\_\_