Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

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	
☐ Age related Osteoporosis without current pathological fracture	ICD10 Code: M81.0
☐ Age related Osteoporosis with current pathological fracture	ICD10 Code: M80.0
☐ Other Diagnosis: _____	ICD10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Serum creatinine and serum calcium level	☐ DEXA scan results and/or FRAX score
☐ Documentation of oral hygiene	☐ Menopause: Age_____ ☐ Hysterectomy: Age_____
List Tried & Failed Therapies, including duration of treatment (please comment specifically on bisphosphonates):	
1)	
2)	

MEDICATION ORDERS			
Dosing	☐ Prolia 60mg SubQ every 6 months		
Refills:	☐ X 6 months	☐ X 1 year	☐ _____ doses

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

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____