

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

PRESCRIBER INFORMATION

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

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____