

MEDICATION ORDERS PROLIA (DENOSUMAB)

Date: _____

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral	☐ Dose or Frequency Change	☐ Order Renewal
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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 _____