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

Provider _____





MEDICATION ORDERS PROLIA (DENOSUMAB) D

Name: Allergies: New Referr Preferred Location*: *List of infusion center locations may be for Please note: Requests will be accommodated and the provided of the provided	INFUSION OFFICE PRE Ound at: https://metroinfusion.ted based on infusion center DIAGNOSIS AN arrent pathological fracture on the pathological fracture REQUIRED DO	r availability and are not guaranteed. ICD10 Code: M81.0 ICD10 Code: M80.0 ICD10 Code:
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, ,		CLIMENTATION
, ,		CLIMENTATION
, ,	ı	COMENTATION
☐ Patient demographics AND insurance	ier	☐ Clinical/Progress notes
	ce information	☐ Labs and Tests supporting primary diagnosis
☐ Serum creatinine and serum calcium	ı level	☐ DEXA scan results and/or FRAX score
☐ Documentation of oral hygiene		☐ Menopause: Age ☐ Hysterectomy: Age_
List Tried & Failed Therapies, including of	duration of treatment (please	e comment specifically on bisphosphonates):
1)		
2)		
		ON ORDERS
Dosing Prolia 6	50mg SubQ every 6 months	
Refills:	nths □ X 1 year	doses
	PRESCIBER IN	FORMATION
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Phone _____ Fax _____