

# 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

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	
<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"/> Patient demographics AND insurance information <input type="checkbox"/> Serum creatinine and serum calcium level <input type="checkbox"/> Documentation of oral hygiene	<input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> DEXA scan results and/or FRAX score <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 \_\_\_\_\_