Prolia

Provider Order Form

PATIENT INFORMATION

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Address:	City:	State:	Zip Code:
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
☐ NKDA ☐ Allergies:		Weight lbs/kg:	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change		Last infusion date (if applicable):	

REQUIRED DOCUMENTATION

☐ Labs Calcium and Dexa Scan results or evidence of Osteopenia (within 6 months)

☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ M81.0 Age-related osteoporosis without current pathological fracture

☐ M81.8 Other osteoporosis without current pathological fracture

☐ T38.0X5A Adverse effect of glucocorticoids and synthetic analogues

☐ Other: _____

MEDICATION ORDER

Prolia (denosumab) **Dose:** ☐ 60 mg SC every 6 months **Patient is currently taking Calcium/Vitamin D Supplement:** ☐ Yes ☐ No

Note: Health Infusion Servicies may substitute with an FDA-approved biosimilar unless otherwise indicated.

PROVIDER INFORMATION

Provider Name:	Provider Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ☐ **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.