



PROLIA® (DENOSUMAB) ORDER FORM

(* - Required Fields)

STAT REQUEST
(*REASON MUST BE PROVIDED BELOW)

New Referral
 Order Renewal
 Medication/Order Change
 Benefits Verification Only
 Discontinuation Order

PATIENT INFORMATION			
NAME*:	DOB*:	SEX:	M F
ADDRESS:	PHONE:		
WEIGHT: LBS KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION			
PHYSICIAN NAME*:		PRACTICE NAME:	
ADDRESS:		OFFICE CONTACT*:	
PHONE:	FAX:	EMAIL (FOR UPDATES):	

PROLIA ORDER*: _____ **ICD-10*:** _____
 (SELECT ONE OF THE FOLLOWING)

Dosing: 60 mg SC every 6 months

Patient is currently taking Calcium/Vitamin D Supplement: Yes No

Physician Signature* _____ Date*(Order is Valid for One Year) _____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

Osteoporosis Senile
 Osteoporosis Postmenopausal
 Glucocorticoid-induced Osteoporosis
 Other _____

***STAT REASON:**
 (STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

Patient Demographics
 Insurance Card/Information
 Clinical/Progress Notes supporting DX
 Current Medication List and H&P
 Serum Calcium Level (w/in 12 months)
 DEXA Results

Last Infusion/Injection Date: _____

STANDING LAB ORDERS: CMP CBC

Labs to be drawn by Infusion Center

NOTES/ADDITIONAL COMMENTS:

Locations:

-----Colorado-----

Lakewood

-----Florida-----

Jacksonville
 Kissimmee
 Port St. Lucie
 Winter Park

-----Texas-----

Arlington
 Cedar Hill
 Dallas
 Denton
 Ft. Worth
 Irving
 Rockwall
 Southlake
 Flower Mound
 Plano
 Tyler

REVISION DATE- 05/2020