

Prolia (denosumab)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status (check one): New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight _____ Please specify: lbs kg Height: _____

Patient Status (check one): New to Therapy Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

DOSAGE

60mg SQ, every 6 months
_____ Last Prolia injection date (if applicable)

DIAGNOSIS

- _____ Age-related osteoporosis **without** current pathological feature
- _____ Age-related osteoporosis **with** current pathological feature
- _____ Cancer treatment-induced bone loss due to hormone ablation therapy (CTIBL-HALT)
- _____

PATIENT WEIGHT

_____ lbs.
_____ kg

PRE-MEDICATION

- Tylenol 1000mg PO
- Diphenhydramine 25mg PO
- Cetirizine 10mg PO
- _____

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

Provider Name (Print)

Provider Signature

Date