PROLIA
(denosumab)

FAX to +1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Baseline LFTs and Lipid Panel
- Bone Density Results
- Medication List
- DEXA Scan
- Current Calcium Level (Within 6 Months
- CrCL Clearance
- Serum creatinine within 1 month of referral
- Tried/Failed or contraindication to oral therapy

PRIMARY DIAGNOSIS

☐ M80.00xA Age-related osteoporosis with current pathological fracture, initial encounter
☐ M80.00xS Age-related osteoporosis with current pathological fracture, sequela
☐ M81.8 Other osteoporosis without current pathological fracture
☐ M81.0 Age-related osteoporosis without current pathological fracture
☐ Other: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for denosumab
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Prolia 60mg (1 60mg SubQ Injection) every 6 months
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date