HONORHEALTH

DENOSUMAB
(Prolia)
Order Form

Outpatient Infusion

Patient Name	
DOB	
Address	
Phone	

Order Status ☐ New Order ☐ Renewal

Diagnosis	☐ Senile Osteoporosis ☐ Osteoporosis w/fracture	☐ Osteoporosis w/out fracture ☐ Other: ______________________________	**Diagnosis Code:** ______________

Required Information (Please send labs included in attachment)	***Allergies:***		
	Dexa Scan (within last 2 years)	Date:	Weight: ___________
	Serum calcium _____ mg/dL	Date:	
	25-Hydroxy Vitamin D level	Date:	Height: ___________
	CMP (please include lab result documents)	Date:	

Labs ☐ CMP & 25-hydroxy vitamin D every ____________ ☐ Other:

Outpatient Supplement
☐ Calcium supplement: _____________ mg/day
☐ Vitamin D supplement: ____________ IU/day
(Recommended calcium 1000mg/day and vitamin D 400 IU/day)

☐ **Prolia** 60mg SQ every 6 months	☐ Refills:

Infusion Reaction Medications Hypersensitivity Reaction Protocol will be utilized unless otherwise specified.

Required Documentation
- H&P or progress note supporting diagnosis
- Medication history
- Recent labs (as above) and/or diagnostic test results

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax: