



Infusion for Health
77 Rolling Oaks Drive, Suite 201
Thousand Oaks, CA 91361
Phone: 805-719-3700 Fax: 805-852-2636

PROLIA ORDER
(Denosumab)

**Please fax a copy of patient's demographics, insurance information, current lab results, H&P, and current medications, Dexa scan showing -2.5 or worse.*

Date: ___/___/___

Patient Name: _____ DOB: ___/___/___

Allergies: _____ Wt: _____ lbs / kg Ht: _____

Diagnosis: _____ ICD-10: _____

Diagnosis made by: T-Score (Dexa) Please list WORST T-score & date: _____

History of fractures? Please list: _____

Tried & failed bisphosphonates? Please list w/dates: _____

Prolia (Denosumab) Dosage:
60 mg subcutaneous every 6 months

Last labs drawn on: ___/___/___ Serum Calcium: _____ Serum Creatinine: _____

Lab work required yearly.

Printed Provider's Name: _____ NPI: _____

Provider's Signature: _____ Date: ___/___/___

Office phone number: _____ Office Fax: _____

Office address: _____ Contact person: _____