Prolia Order

(Denosumab)

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ___/___/___ Treatment Location: _____

***Please fax a copy of the following patient information:**

- ☐ Demographics
- ☐ Insurance Information
- ☐ Current Lab Results
- ☐ H & P Relevant to the Diagnosis
- ☐ Medication List
- ☐ DEXA Scan Report

PATIENT INFORMATION

Patient Name: _____

DOB: ___/___/___

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ___/___/___

Phone: (___) ___-____ Fax: (___) ___-____

Office Address: _____

Contact Person: _____

DIAGNOSIS

Diagnosis made by: T-Score (DEXA) Please list WORST T-Score: _____ Date: ___/___/___

Tried and Failed Bisphosphonates? Please list with dates: _____

Please list any history of fractures: _____

PROLIA (DENOSUMAB) DOSAGE:

60 mg subcutaneous every 6 months

Last labs drawn on: ___/___/___

Serum Calcium: _____ Serum Creatinine: _____

Lab work required yearly.

Revised 12/01/20