Prolia Order

(Denosumab)

InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:**
☐ Demographics ☐ Insurance Information ☐ Current CBC & CMP
☐ 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: _____

Contact Email: _____

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:

Date of Last Treatment, If Continuation:

60 mg subcutaneous every 6 months

Last labs drawn on: _____

Serum Calcium: _____ Serum Creatinine: _____

Lab work required yearly.

Revised 04/15/22