



(denosumab)

PROLIA injection orders

Patient Name _____

DOB _____

Phone _____

M _____

F _____

DIAGNOSIS Please provide ICD-10 code

Age-related osteoporosis **without** pathological feature (high risk of developing fracture) M81.0

Age-related osteoporosis **with** current pathological feature

Cancer treatment-induced bone loss due to hormone ablation therapy (CTIBL-HALT)

(other)

PRE-MEDICATION

Tylenol 1000mg PO

Cetirizine 10mg PO

Diphenhydramine 25mg PO

- * Referring physician is responsible for monitoring and reviewing serum Calcium level prior to dose of Prolia. *(other)*
- * Clinical monitoring of calcium, phosphorus, and magnesium is highly recommended in patients with severe renal impairment
- * Adequately supplement all patients with Calcium and vitamin D.

PROLIA ORDERS

DOSAGE	PATIENT WEIGHT
60mg SQ, every 6 months	lbs.
Last Prolia injection date <i>(if applicable)</i>	kg

REQUIRED DOCUMENTATION

- Signed order form by the provider
- Patient demographics AND insurance information
- Clinical/progress notes supporting primary diagnosis
- Calcium drawn and noted to be WNL and results sent
- DEXA scan results and/or FRAX score
- Notes:

Please fax completed forms to Wellspring Health at **(563) 900-8290**.

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____

Phone _____

Fax _____