

Provider Order Form
PROLIA (DENOSUMAB)



PATIENT

Full Name: _____ DOB: _____
Mobile Phone: _____ Weight: _____ lbs kg
Allergies: _____ NKDA
Patient status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

Age-related osteoporosis with current pathological fracture M80. _____ Age-related osteoporosis without current pathological fracture M81. _____
 Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____
Practice Name: _____ Referral Coordinator Name: _____
Practice Address: _____
Phone: _____ Fax: _____ Email: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
<input checked="" type="checkbox"/> Prolia (Denosumab), Subcutaneous Injection	<input checked="" type="checkbox"/> 60 mg	<input checked="" type="checkbox"/> Every 6 months

Refills Zero 12 months _____ Order valid for 1 year unless otherwise stated. _____

Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

<input type="checkbox"/> CBC	<input type="checkbox"/> at each dose	<input type="checkbox"/> every _____
<input type="checkbox"/> CMP	<input type="checkbox"/> at each dose	<input type="checkbox"/> every _____
<input type="checkbox"/> CRP	<input type="checkbox"/> at each dose	<input type="checkbox"/> every _____
<input type="checkbox"/> Other _____		

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

Patient Demographics Patient Demographics Progress Notes supporting DX Dexa Results

Provider Signature _____ Date _____