

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

- Patient Demographics
 Insurance card
 Progress Notes supporting DX
 Dexa Results
 Creatinine clearance and Calcium levels

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 type="checkbox"/> Prolia (Denosumab), Subcutaneous Injection	<input type="checkbox"/> 60 mg	<input type="checkbox"/> Every 6 months
<input type="checkbox"/> Denosumab Biosimilar, Subcutaneous Injection: <input type="checkbox"/> Jubbonti <input type="checkbox"/> Wyost <input type="checkbox"/> Bilydos <input type="checkbox"/> Stoboclo <input type="checkbox"/> Enoby	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> Other	<input type="checkbox"/> _____	<input type="checkbox"/> _____

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

 Provider Signature Date