

MRN: _____

Palmetto Infusion Services
Standard Plan of Treatment for Prolia

(Re)Certification Period From _____ to _____

Note: We may require MD office notes and may require a letter of Medical Necessity, to be able to verify eligibility and payment for this treatment through patients insurance plan.

Patient Name _____ **Weight:** _____

Allergies: _____ **Height:** _____

DIAGNOSIS: **733.01 Senile Osteoporosis,** **733.00 Osteoporosis, unspecified**

Is the patient on calcium and Vitamin D replacement? **Yes** **No**

Pertinent Medical History:
T- Score (if known) _____
Histry of Osteoporotic Fracture: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known Skeletal Site: _____
Other risk fractures for Osteoporotic fracture(if any) _____
Prior Postmenopausal Treatment History: <input type="checkbox"/> Generic Alendronate <input type="checkbox"/> Fosamax® <input type="checkbox"/> Actonel® <input type="checkbox"/> Boniva®
Reason for discontinuing therapy: _____
Contraindications (if any) _____
Other pertinent medical information: _____

Orders:

Obtain weight each visit (as patient tolerates). Monitor pre-injection vital signs, every visit. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy. Supplies needed to administer prescribed drug therapy. **If Adverse Drug Reaction, Implement the Standing Adverse Reaction Protocol.**

Drug:

Prolia 60mg subcutaneously every 6 months

Lab-work:

BMP prior to each dose of Prolia- hold dosing if Calcium subtherapeutic.

Pharmacist to perform clinical drug monitoring

(No Stamped Signature Please)

Physician Signature: _____ / _____ Date: _____
(Dispense as written) (Substitution permitted)

Please fax Demographics and Insurance Information to:
TOLL FREE FAX (866) 872-8920
