

Phone: 800-809-1265

MRN: _____

DOB: _____

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 (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patients Medicare and/or other insurance plan.

Patient's Name _____ HT: _____ Weight: _____ Allergies: _____

DIAGNOSIS: 733.01 Senile (post menopausal) Osteoporosis 733.00 Osteoporosis, unspecified
 174.____ Malignant Neoplasm of Breast 185 Malignant Neoplasm of Prostate
AND
 V07.59 Use of other agents affecting estrogen receptors and estrogen levels
OR
 V58.69 Long-term current use of other medications

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

Pertinent medical information: _____
T- Score (if known): _____
History of Osteoporotic Fracture: Yes No Not known Skeletal Site: _____
Other risk fractures for Osteoporotic fracture (if any): _____
Prior Postmenopausal Treatment History: Generic Alendronate Fosamax® Actonel® Boniva®
Reason for discontinuing therapy: _____
Contraindications (if any): _____

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 Orders:**

BMP prior to each dose of Prolia - hold dosing if Calcium sub-therapeutic

Pharmacist to perform clinical drug monitoring

(No Stamped Signatures Please)

Physicians Signature: _____ Date: _____
(Dispense as written) (Substitution Permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920