Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265 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