

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Prolia® (denosumab) Standard Plan of Treatment
PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
	See list
	NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

M81.0 - Age-related Osteoporosis without current fractures	Z79.818 - Long-term use of agents affecting estrogen receptors and estrogen levels
C61 - Malignant neoplasm of the Prostate	
C50.919 Malignant neoplasm of unspecified site of unspecified female breast	Z79.899 - Long-term current use of other medications
- Other:	

REQUIRED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	REQUIRED	LAST INJECTION DATE:
3	Full medication list	WASHOUT FROM	NEXT INJECTION DATE:
4	Tried and failed therapies	PREVIOUS	IF ORDER CHANGE:
5	Most recent Bone Density Scan result	THERAPY:	Continue current order until insurance approved
6	Calcium levels drawn within 60 days prior to 1st Injection then annually		

MEDICATION ORDERS:

NOTE: Patient **may be ineligible** to receive Prolia® if serum calcium levels are sub-therapeutic, receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection. ONJ is a risk for patients on denosumab. A routine oral exam is recommended to be performed by the prescriber prior to start of treatment.

DOSE/FREQUENCY:

Prolia® (denosumab) 60mg subcutaneously every 6 months.
Administer as subcutaneous injection only to upper arm, upper thigh, or abdomen.

Prescriber clearance waived for recent or planned dental procedures.

SPECIAL ORDERS:

LAB PARAMETERS: (Pharmacist to perform clinical lab monitoring)

Check here to indicate the prescriber will be responsible for clinical lab monitoring

If serum Calcium is below normal range, dose will be held unless signed and dated clearance is provided by prescriber.

Refills x 12 months unless noted otherwise here:

CARE ORDERS:

Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.


PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)
DATE

_____	_____	_____
Dispense as written/Brand medically necessary	Substitution permitted	