

Denosumab (Prolia)

Provider Order Form rev. 1/23/2025



PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____
Patient Address: _____ Patient Email: _____
Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

M80. ____: Osteoporosis w/ pathological fx M81. ____: Osteoporosis w/o pathological fx
 Other: _____ Description: _____

REQUIRED INFORMATION

- Last serum Ca+ drawn on _____ Result: _____ (please send with order).
 Ok to use this lab result for Prolia injection.

THERAPY ADMINISTRATION

- Administer Prolia 60 mg subcutaneously in the upper arm, abdomen, or upper thigh.
 Following initial Prolia injection, observe patient for 15 minutes for hypersensitivity. Patients who have previously received and tolerated Prolia do not require observation period.

FREQUENCY (Choose one)

- Repeat once in 6 months.
 Other: _____

LABORATORY ORDERS

- Order for serum calcium to be repeated 7-14 days before next 6-month dose provided to patient.
 Other: _____

PRE-MEDICATION ORDERS

- Other: _____

NURSING

- Hold infusion and notify provider for:
- Signs or symptoms of active infection or chance of pregnancy.
 - Planned/recent invasive dental procedures.
 - Jaw, thigh or groin pain, or dermatologic changes since starting Prolia.
 - A history of severe bone, muscle or joint pain following Prolia injections.
 - Lab levels showing hypocalcemia.
 - Patient must be on Calcium and vitamin D orally unless contraindicated.
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with biphosphates, Reclast, Prolia, Evenity. History of GERD, fractures, T score

Required Labs: Calcium and Vitamin D levels, Renal function

Provider Name (print) _____

Provider Signature _____

Date _____

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.