Denosumab (Prolia)

Provider Order Form rev. 7/29/2025

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.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.