Prolia (denosumab)

Order Form
Rev. 11/06/2023

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PATIENT INFORMATION **Referral Status:** ◯ New Referral ◯ Updated Order ◯ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description *(required)*:

☐ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to IA.

The patient has an existing prior authorization: ◯ Yes *(please fax IA a copy)* ◯ No *(IA will process for you)*

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

CLINICAL HISTORY

Attach most recent DEXA scan results: Date: ___________________________ T-Score: ____________________

Vit D 25-OH (if available) : Date: ________ Levels : __________

Has the patient previously tried Reclast? ◯ No ◯ Yes. If yes, specify below:

Is the patient currently taking calcium and vitamin D? ◯ Yes ◯ No, reason for not taking: ________________

In the past **TWO** years, what medications for the above diagnosis has the patient tried and failed?

Drug & Dose	Dates of Use	Drug & Dose	Dates of Use

Does the patient have a diagnosis or history of any of the following? (Check all that apply):

- ☐ Hypocalcemia
- ☐ History of hypoparathyroidism
- ☐ Thyroid or parathyroid surgery
- ☐ Severe renal impairment (CrCl<30)
- ☐ Malabsorption syndromes
- ☐ Recurrent UTI
- ☐ Recent tooth extraction or jaw surgery
- ☐ **NO** the patient does **NOT** have history of any of the above

Serum calcium is required within 3 months of appointment.

Result Date: _________________ Lab Result: ________________

Contraindicated in patients with hypocalcemia.

THERAPY ADMINISTRATION

Prolia (denosumab) Subcutaneous Injection

Dose: 60 mg

Frequency: Every 6 months for a total of 2 doses per year.

Date of last injection if not at IA: ____________ RX Expiration Date: ____________

Additional Notes from Referring Office:

________________________________ ________________________________ ________________________

Provider Name (Print) **Provider Signature** **Date**