METRO INFUSION CENTER

MEDICATION ORDERS- PROLIA (DENOSUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Age related Osteoporosis without current pathological fracture	ICD10 Code: M81.0
☐ Age related Osteoporosis with current pathological fracture	ICD10 Code: M80.0
☐ Other Diagnosis: ____	ICD10 Code: ______________________

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Serum creatinine and serum calcium level	☐ DEXA scan results and/or FRAX score
☐ Documentation of oral hygiene	
List Tried & Failed Therapies, including duration of treatment (please comment specifically on bisphosphonates): 1) 2)	

MEDICATION ORDERS	
Dosing	☐ Prolia 60mg SubQ every 6 months
Refills:	☐ X 6 months ☐ X 1 year ☐ _____ doses

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164