Denosumab (Prolia)

MIC | METRO INFUSION CENTER

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

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:	DOB:	
☐ NKDA Allergies:	Weight (lbs / kg):	Height:	
Patient Status: ☐ New to Therapy	☐ Continuing Therapy - Last Treatment Date:	Next Due Date:	
PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
DIAGNOSIS AND ICD 10 CODE			
☐ Osteoporosis in women or men at high risk of developing fracture	ICD-10 Code: M81.0		
☐ Other Diagnosis:	ICD-10 Code:		

REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx	☐ Calcium drawn and noted to be WNL and results sent ☐ DEXA scan results and/or FRAX score
List Tried & Failed Therapies 1)	2)

MEDICATION ORDERS
☐ Prolia 60mg SubQ every 6 months x1 dose*
☐ Prolia 60mg SubQ every _____ months x1 dose*

SPECIAL INSTRUCTIONS

** 1 dose is allowed to be ordered per referral form. Referring physician is responsible for monitoring and reviewing serum Calcium level prior to dose of Prolia.*

*** Clinical monitoring of calcium, phosphorus, and magnesium is highly recommended in patients with severe renal impairment Adequately supplement all patients with Calcium and vitamin D.*

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

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Revised 1/27/23