MIC | METRO INFUSION CENTER

Denosumab (Prolia or Biosimilar)

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			
☐ **Denosumab 60mg SubQ every 6 months** *(Pharmacy to dispense based off of product availability)* ☐ **Dispense as written Prolia (no substitutions)**			

SPECIAL INSTRUCTIONS

** 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.

Revises 9/10/25