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