



Phone:616-954-0600 Fax: 616-954-1675

Prolia Injection

Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and Recent Visit Notes

Referral status: NEW referral Dose or frequency change Order renewal

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Patient Weight: _____ lbs / kg Height: _____

Diagnosis : Osteoporosis, please specify ICD-10 code: _____
 Other: please specify: _____

Attach most recent DEXA scan results: Date: _____ T-Score: _____

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

N/A continuation of treatment

Drug	Dose	Dates of use

Does 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

**Prolia (denosumab) 60 mg subcutaneous injection
Every 6 months for total of 2 doses per year**

Serum calcium required within **3 months** of appointment
Result date: ____/____/____
Lab Result : _____
Contraindicated in patients with hypocalcemia

Printed provider name: _____

Provider signature: _____

Office phone number: _____ Fax number: _____