Infusion ASSOCIATES®

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: _____
Has the patient previously tried Reclast? ☐ No ☐ Yes. If yes, specify below
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:** _____