PROLIA SUB Q

****REQUIRED INFORMATION****

- ☐ This order form signed by provider
- ☐ Patient demographics & insurance information
- ☐ Clinical/Progress notes, labs, test supporting primary diagnosis
- ☐ DEXA scan: (-2.5 T score or more severe)
  - o If no -2.5 T score, please send history of fracture documentation
- ☐ Required labs: Calcium within 6 months, CrCl if CKD

Patient Name:	DOB:
Allergies:	Patient phone:

Diagnosis:

☐ Senile osteoporosis (ICD10:________)

Glucocorticoid-induced osteoporosis (ICD-10:___________)

☐ Paget's Disease (ICD10:__________)

☐ Other:_____________________ (ICD10:_______________)

J Code: J0897

Patient weight: _____________ kg

Prolia Orders

*Patient is currently taking calcium/vitamin D supplementation ☐ Yes ☐ NO

- ☐ Prolia 60 mg subcutaneous injection every 6 months
- ☐ Prolia 120mg subQ every 4 weeks, give an additional 120mg on days 8 and 15.

*Date of last Prolia injection: ___________________

Additional instructions:

Physician Name:	Phone:	Fax:

Physician signature:	Date: