RED RIVER HEALTH
Ambulatory Infusion Clinic

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PROLIA (denosumab) Injection Orders

Patient Name: _____ DOB: _____ ☐ M ☐ F

☐ NKDA Allergies: _____

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____ Provider NPI: _____

Practice Phone: _____ Practice Fax: _____

Diagnosis *(please provide ICD-10 code)*:

☐ _____ Age-related osteoporosis ***without*** current pathological fracture

☐ _____ Age-related osteoporosis ***with*** current pathological fracture

☐ _____ _____
(other)

Tried and Failed Medications:

☐ Actonel
☐ Boniva
☐ Evista
☐ Fosamax
☐ Reclast
☐ Contraindications to above: _____

Required Documents:

☑ Patient Demographic Sheet
☑ Clinical/Progress Notes supporting primary diagnosis *(please attach)*
☑ DEXA Scan results & date (*please attach)*
☑ Recent CMP lab results (*please attach)*

PROLIA ORDERS:

Dosing/Frequency: ☐ 60mg SQ, every 6 months

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: _____ Date: _____