

## 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)*
- Calcium level & date *(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: \_\_\_\_\_