

PROLIA® (denosumab)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
DOB: _____ Allergies: NKDA _____
Phone Number: _____
Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List Serum calcium level within one year of injection
 Clinical/Progress Notes Supporting Dx DEXA scan and/or FRAX score

Primary Diagnosis

 ICD-10 Code (required): _____

- Osteoporosis
 Glucocorticoid-induced osteoporosis

Other: _____

Therapy Administration

- Prolia subQ 60mg every 6 months
 Other: _____

Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)

RN to administer ordered therapy per manufacturer guidelines.

Other: Please fax alternative reaction orders or nursing administration orders if checking this box

Refills:

- x 1 year Other: _____

 Order valid for one year unless otherwise stated

Special Orders

Provider Information

Provider Name: _____ Office Contact Person: _____
Referring Practice Name: _____ Phone Number: _____
Referring Practice Address: _____ Fax Number: _____
City, State, Zip: _____ Email: _____
Provider NPI: _____
Provider Signature: _____ Date: _____