(denosumab)

PROLIA injection orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

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

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

☐ _____ Cancer treatment-induced bone loss due to hormone ablation therapy (CTIBL-HALT)

☐ _____ _____
(other)

☐ Length of Need _____

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____
(other)

PROLIA ORDERS

DOSAGE

◯ 60mg SQ, every 6 months

_____ Last Prolia injection date *(if applicable)*

PATIENT WEIGHT

_____ lbs.

_____ kg

◯ Refills: _____

Notes

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Address _____

_____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887