The Outpatient Infusion Center
a Service of Comanche County Memorial Hospital

Phone: 580-250-5899
Fax: 580-585-5472

PROLIA ORDER FORM

PATIENT INFORMATION

Last Name: ____ First Name: ____ MI________
HT: ___________ WT: ___________ DOB: _________________ Sex :( ) Male ( ) Female SSN:______________________________
Street Address____ City/State/Zip ____
Home Phone # _______________________________ Work # _______________________________ Cell # ________________________________

INSURANCE INFORMATION

Primary Insurance Name____ Policy ID# ________________________
Secondary Insurance Name____ Policy ID# ________________________

PHYSICIAN/FACILITY INFORMATION

Physician's Name_______________________________ Contact Name __________________________ Contact Phone # ____________________
Address _____________________________________ City/State/Zip__________________________________Fax #:________________________
DEA# ________________________________ NPI # _______________________________ State License # _______________________________

STATEMENT OF MEDICAL NECCESITY

Primary Diagnosis (ICD 10 code AND CPT code) ____
Secondary Diagnosis (ICD 10 code AND CPT code) ____

MEDICAL INFORMATION

Does the patient have venous access? ☐ Yes ☐ No If yes, what type? ____
Is the patient incontinent? ☐ Yes ☐ No Comments: ____
Is the patient ambulatory? ☐ Yes ☐ No Comments: ____

PRESCRIPTION ORDERS:

ADMINISTER PROLIA 60mg SUBCUTANEUOUS ONCE EVERY 6 MONTHS

INCLUDE COPIES OF THE FOLLOWING:

- **BMP WITHIN THE LAST 30 DAYS – OTHERWISE ONE WILL BE DRAWN**
- **BONE DENSITY/DEXA SCAN WITHIN THE LAST 2 YEARS – OTHERWISE ONE WILL BE PERFORMED PRIOR TO THE DATE OF SERVICE**
- **OFFICE NOTES SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS/OSTEOPENIA DATED WITHIN THE LAST 2 YEARS**
- **H&P DATED WITHIN THE LAST 2 YEARS**
- **PRIOR MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS/OSTEOPENIA**

Labs Needed: **BMP– UNLESS PROVIDED**____

Provider's Signature:____**Date:**____________________ **Time:**_________________

Fax completed form to the Outpatient Infusion Center at 580-585-5472. PLEASE include copies of: H&P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, LETTER OF NECESSITY or any other documentation supporting the use of infusion therapy, and ALL current insurance information for your referral to be processed.