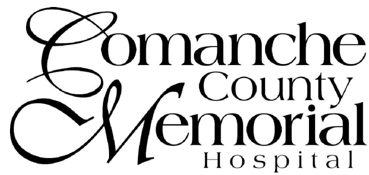

Outpatient Infusion Center
Prolia Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender: M F

Patient Address: Email: Insurance:

Additional Information Needed

- Fax front/back of insurance card
- Fax patient demographics
- Fax clinical/progress notes
- Fax current medication list
- Fax labs
- Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

- M80.0 Age-Related Osteoporosis with current pathological fracture
- M81.0 Age-related Osteoporosis without current pathological fracture
- M81.8 Other Osteoporosis without current pathological fracture
- Other: DX: ____________________

Clinical Information:

New Therapy Induction Therapy Change Therapy Continuation

Patient Weight:________ lbs/ ________ kg Patient Height: ________ in/_______ cm

Allergies:____________________

Therapies Tried and Failed: ____________________

TB Test: Date: ___________ Results: ___________ Hep B Test: Date:___________ Results:___________

Is patient currently taking Calcium/ Vitamin D supplements? Yes or No Date of Last Calcium/ Vitamin D: ___________

Is the patient currently taking XGEVA? Yes or No

Is the patient potentially pregnant? Yes or No

Date of last Dexa scan:___________ Clinical Note for last DEXA scan attached? Yes No

Lab Orders

CBC w/o diff CMP ESR CRP Pregnancy Test

Other: ____________________

Lab Orders to be done by

- Infusion Services
- Referring Provider

Prescription Information

Prolia	Dose: 60mg	Frequency: Every 6 months

Misc Orders

____

____

PICC/Midline/CAD dressing to be changed every 7 days

Flushes

- 10mL NS Flush Syringe PRN
- Heparin 500units/5mL Flush Syringe PRN
- 50ml NS Bag PRN
- 250ml NS Bag PRN

Standing Orders for Adverse Reaction

- Stop infusion and initiate NS bolus
- Notify Supervising physician and ordering provider
- Solu-Cortef 100mg SIVP signs of adverse reaction
- Benadryl 25 mg SIVP for hives or bronchial inflammation
- Epi 1:1000 1mL IM, IV or SQ for anaphylaxis
- Oxygen 2-5L nasal cannula
- Albuterol 2.5mg inhaled PRN to chest tightness
- Other: ____________________

Prescriber Information

Physician Name: ____________________ Official Contact Name: ____________________

Contact #: ____________________ Fax Number: ____________________

Address: ____________________ City/State/Zip: ____________________

NPI#:__________ DEA#: __________ State License #: ____________________

Physician's Signature Date Time