

Prolia® (denosumab)

Referring Physician Order Form Rev. 4/2025

Please fax completed referral form & all required documents to 208-595-4427

**PATIENT DEMOGRAPHICS**

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City/ST/Zip: _____
Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm
Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).**DIAGNOSIS***

***ICD 10 Code Required** ☐ Osteoporosis with current fracture (M80.0 – M80.8), ICD10 _____ ☐ Other: _____, ICD10 _____
☐ Osteoporosis without current fracture (M81.0)

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Prolia® (denosumab)	60 mg	Inject SUBQ every 6 months

Is patient currently receiving therapy above from another facility?☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP
☐ Other: _____

LAB ORDERS**Labs to be drawn by:** ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time
☐ Blood glucose q _____ ☐ CBC with diff/platelet q _____
☐ CMP q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
Physician Name: _____ Provider NPI: _____ Specialty: _____
Address: _____ City/ST/Zip: _____
Contact Person: _____ Phone #: _____ Fax #: _____
Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION**Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.**☐ Yes ☐ No Is the patient at high risk for fractures?

If yes, please select all that apply:

☐ History of fragility (non-traumatic) fracture☐ Multiple risk factors for fracture:☐ anorexia nervosa☐ alcohol intake (4 or more units/day)☐ corticosteroid therapy☐ smoking☐ Other: _____☐ elderly☐ low body mass☐ parental history of hip fracture☐ rheumatoid arthritis**LAB AND TEST RESULTS (required)**☐ Bone Mineral Density (BMD) test ☐ Other: _____**PRIOR FAILED THERAPIES FOR OSTEOPOROSIS (including oral/IV bisphosphonates, SERM)**

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
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