vitalcare INFUSION SERVICES of SIOUX FALLS

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PROLIA SUB Q

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ Dexa Scan (-2.5 T score or more severe)
  ***if no -2.5 T score, please send history of fracture documentation*
- ☐ Documentation to support primary diagnosis
  (Clinical/progress notes, other medications tried & failed, labs, diagnostic tests, etc.)
- ☐ **Required Labs:** Calcium within 6 months, CrCl if CKD

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis ICD-10: ☐ Senile Osteoporosis (ICD-10:_____) ☐ Paget' s disease of bone (ICD-10:_____)
☐ Glucocorticoid-induced osteoporosis (ICD-10:_____) ☐ Other (ICD-10:_____)

J Code: J0897

PROLIA SUB Q ORDERS

Patient Wt._____kg

*Patient is currently taking calcium/vitamin D supplementation ☐ YES ☐ NO

☐ Prolia 60 mg subcutaneous injection every 6 months

☐ Prolia 120mg subQ every 4 weeks, give an additional 120mg on days 8 and 15.

*Date of last Prolia injection:_____

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	