



PATIENT INFORMATION

PATIENT NAME: PHONE #: ADDRESS: CITY, STATE, ZIP: DATE OF BIRTH: EMAIL: ALLERGIES: [] SEE LIST [] NKDA WEIGHT: [] LB OR [] KG

REQUIRED DOCUMENTATION

- 1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List 6. DEXA Scan 7. Current Calcium Level (within 6 months) 7. CrCl clearance

PRIMARY DIAGNOSIS

[] M80.00xA Age-related osteoporosis with current pathological fracture, initial encounter [] M80.00xS Age-related osteoporosis with current pathological fracture, sequela [] M81.0 Age-related osteoporosis without current pathological fracture [] Other

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic:

PRE-MEDICATIONS

[x] Per infusion clinic protocol: There are no recommended standard pre-meds for Prolia [] Provider Prescribed:

PRIMARY MEDICATION ORDER

Denosumab [] Denosumab 60mg Subcutaneously every 6 months x 2 doses [] Other: FIRST DOSE?: [] Yes [] No [] Refill x12 months unless otherwise noted. Prolia or biosimilar (Jubbonti) may be used according to payer guidelines. To prohibit auto-substitution, please indicate specific brand required:

ADVERSE REACTION & ANAPHYLAXIS ORDERS

[x] Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy) [] Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: PHONE: OFFICE CONTACT: FAX: ADDRESS: EMAIL: CITY, STATE, ZIP: NPI AND LICENSE:

X PROVIDER SIGNATURE DATE