PROLIA ®Infusion Form

Fax Referral To: 877-438-9380

CONTINUUMRX Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y◯ N◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

_____ Age-related Osteoporosis with current fracture
_____ Age-related Osteoporosis without current fracture
_____ Other: _____

Please attach the following: 1. Clinical MD Notes, labs, test supporting primary diagnosis, Any recent history of heart attack or stroke in the past year. 2. Documentation of therapies previously trialled and failed 3. Dexa Scan Results indicating osteoporosis 4. Recent serum calcium 5. Recent dental exam results 6. Current medication list: Patient is currently receiving calcium/vitamin D supplementation: ◯Yes ◯No ◯ Other:_____, Was the patient previously receiving a bisphosphonate: Yes ◯No ◯, If yes, therapy was discontinued: _____, If yes, desired wash-out period prior to starting Prolia: _____weeks 7. Copy of patients Insurance Card

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **PROLIA® (denosumab)**
60 mg every six months

New Start:

_____ # Refills (Recommend 1 Refills)

☐ **Administer 60 mg subcutaneously every six months**
Date of last Prolia injection: _____

☐ **N/A**

Pre-Medication Orders:

Acetaminophen 650 mg PO administered 30 min prior to infusion *adjust to patient's needs
Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)
By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date