



Patient Name: _____
 DOB: _____
 Date of Last Infusion _____
 Insurance: _____

Clinic Location:
 Merrimack, NH
 Concord, NH

Denosumab (Prolia®) Orders

Diagnosis (please provide ICD-10 code in space provided):	
_____ Post-menopausal osteoporosis (ICD-10)	_____ Male osteoporosis (ICD-10)
_____ Cancer treatment-induced osteoporosis (ICD-10)	_____ Other: _____ (ICD-10)
Date of last Prolia injection (if applicable): _____	
Serum calcium results required. Results should be obtained no more than 14 days prior to treatment. Please choose one: <input type="checkbox"/> Lab results attached. Date collected: _____ <input type="checkbox"/> Patient has been provided with lab order and instructions to have drawn within two weeks of scheduled injection. To prevent delays in patient care, please indicate on lab order "CC results to Infusion Services: fax (603) 570-1470"	

Nursing:

- Hold medication and notify provider for:
 - Signs or symptoms active infection
 - Planned/recent invasive dental procedures
 - Jaw, thigh or groin pain, or dermatologic changes since starting Prolia
 - A history of severe bone, muscle or joint pain following Prolia injections
 - Hypocalcemia (or calcium level within 14 days unavailable)

Dose: Administer **Prolia 60 mg subcutaneously** in the upper arm, abdomen or upper thigh.

Frequency:

Repeat once in 6 months

Additional Orders:

Provider name (print): _____ Date: _____

Provider signature: _____ Time: _____