LIFEBRIDGE HEALTH
CARE BRAVELY

DENOSUMAB (Prolia®) ORDER FORM

Patient Label

Patient Name: _____ DOB: _____

Diagnosis: _____ Diagnosis Code: _____ Height: _____

Allergies: _____ Weight: _____

Prolia® is not for use in patients already receiving Xgeva®, Reclast® or Zometa®

Pre-appointment Documentation:

Please fax most recent office visit note documenting the patient's diagnosis, a copy of the lab results below, as well as a copy of the patient's demographic information along with this order form.

Pre-appointment Lab Results:

Patients on antiresorptive therapy should have bone densitometry/DEXA scan repeated every 2 years.

☐ **Date of most recent DEXA scan:** _____

The following lab tests must be ordered, completed and results documented within 30 days prior to the administration of denosumab. Fax a copy of lab results with this order form.

☐ Calcium **Date obtained:** _____ **Result:** _____

Does the patient have any dental concerns that would prohibit receiving denosumab? ☐ **No** ☐ **Yes**

If yes, explain: _____

List prescribed supplemental calcium and vitamin D medications and dosages below:

Calcium: _____

Vitamin D: _____

NOTE: Pre-existing hypocalcemia and vitamin D deficiency should be corrected prior to initiation of therapy

List the date of last dose of previously prescribed antiresorptive therapy below:

Name of therapy: _____ Date last administered: _____

☐ Not previously on antiresorptive therapy

Treatment:

☒ Denosumab (Prolia®) 60mg subcutaneously every 6 months

Physician's Name (Print): _____ Signature: _____ Date: _____

Contact Number: _____ Fax Number: _____

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