



Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Prolia Order Form

Patient Name: _____ DOB: _____
Phone: _____ Address: _____
City: _____ State: _____ Zip: _____ Email: _____
Sex: _____ Height: _____ Weight: _____ Allergies: _____

DIAGNOSIS:

- ☐ Age-related osteoporosis without current pathological fracture ICD-10: _____
☐ Age-related osteoporosis with current pathological fracture ICD-10: _____
☐ Other _____ ICD-10: _____

ORDER FOR PROLIA (DENOSUMAB):

- ☒ Prolia (denosumab): 60 mg SC every 6 months x 1 YEAR

☐ Patient is currently taking Calcium/Vitamin D Supplement:
☐ Yes OR ☐ No

****DEXA Scan - please attach results****

PRE-MEDICATIONS:

- ☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
☐ Additional Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☒ Nevada Infusion Hypersensitivity Reaction Order Set
☐ Other: _____

NURSING: Per Nevada Infusion

LABS ORDERS: _____
Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI: _____
Physician Signature: _____ Date: _____
Point of Contact: _____ Phone: _____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

****Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. ****



Patient Name: _____ DOB: _____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

- ☐ Signed Provider orders (page 1)
- ☐ Patient demographic and insurance information
- ☐ Patient's current medication list
- ☐ Supporting recent clinical notes and H&P (to support primary diagnosis)
 - ☐ Original Diagnostic T-Score: _____ T-Score Date: _____
 - ☐ History of osteoporotic fracture
 - ☐ Prior Osteoporosis Therapy (if any):
 - ☐ Generic alendronate
 - ☐ Fosamax® (alendronate sodium)
 - ☐ Actonel® (risedronate sodium)
 - ☐ Boniva® (ibandronate sodium)
 - ☐ Other _____
 - ☐ Reason for Discontinuing Previous Osteoporosis Therapy(ies): _____
 - ☐ Contraindications (if any): _____
 - ☐ Patient is currently taking calcium and vitamin D supplements:
 - ☐ Yes OR ☐ No
 - ☐ Calcium level available:
 - ☐ Yes OR ☐ No

Any Additional Pertinent Information: _____

Additional REQUIRED Information:

- ☐ Include labs and/or test results to support diagnosis
- ☐ Calcium levels (within 6 months) - please attach results
- ☐ **DEXA Scan - please attach results**
- ☐ Other medical necessity: _____

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