

PROLIA ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Preferred Location: _____

Patient Information

Patient Name:	DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address:	Phone:	Email:
Height (in):	Weight (lb):	Referral Status: <input type="checkbox"/> New <input type="checkbox"/> Updated <input type="checkbox"/> Renewal

Infusion/ Injection Information

Primary ICD-10 Code:	Primary ICD-10 Description:
Other ICD-10 Codes:	Other ICD-10 Descriptions:

Prolia (Denosumab) Dosing Info:

60mg SubQ every 6 months

Required Documentation:

- Full Patient Chart
- Insurance Cards (Front and Back)
- Clinical Notes Supporting Diagnosis
- List of Current Medications, Conditions, and Allergies
- Serum Creatinine and Calcium Levels
- DEXA Scan or FRAX Score

Premedications:

- Acetaminophen _____ mg
 PO IV
- Cetirizine _____ mg PO
- Diphenhydramine _____ mg
 PO IV
- Hydrocortisone _____ mg IV
- Loratadine _____ mg PO
- Methylprednisolone _____ mg IV
- Other: _____ mg
 PO IV

Ordering Provider Information

Practice Name:	Practice Phone:	Practice Fax:
Practice Address:	Referral Coordinator Name:	
Referral Coordinator Email:	Referral Coordinator Phone:	
Ordering Provider:	Provider NPI:	Specialty:

All Injections, Infusions, and Rescue Management for Reactions will be handled in accordance with Wells Infusion's Protocols. Orders are valid for 1 year unless stated otherwise.

Provider Name

Provider Signature

Date