PURE INFUSION SUITES

PROLIA ORDER FORM

UTAH PROVIDERS Fax form to:
1-801-991-6924

ALL OTHER PROVIDERS Fax form to:
1-801-931-2631

you must enter a 1 before the fax number

Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis

Allergies

Please fax most recent TB test results & DEXA Scan.

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

PROLIA DOSING

☐ 60 mg/ml injection subQ once every 6 Months

Calcium Level: Correct hypocalcemia prior to Prolia injection

☐ Within 2 weeks of Prolia injection (Strongly recommended for patients with history of/or condition that causes hypocalcemia)

Result | Date

☐ Use most recent calcium level

Result | Date

Phosphate level

☐ At initation of therapy (strongly recommended)

Vitamin D level

☐ Yearly (strongly recommended)

INFUSION REACTION ORDER, CHOOSE ONE:

☐ Pure's Infusion Reaction Protocol

☐ Attached Infusion Reaction Protocol

Don't forget to attach patient demographics with corresponding insurance information, DEXA scan, calcium, phosphate and vitamin D levels, and notes of previously tried therapies.

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature

Date/Time

Provider Phone | Provider Fax