Prolia (Denosumab)
Infusion Order

Fax to 801.931.2631 or Email to intake@purehealthcare.com

PATIENT INFORMATION

Patient Name: ______________________________ DOB: _____________ Phone: ______________

Patient Sex: _____ Patient Weight: _____ kg Patient Height: _____ in Patient Email: ____________________

Patient Status: ☐ New Patient ☐ Continuing Therapy Last Infusion Date (if applicable): _______________

DIAGNOSIS DETAILS

☐ Age-related osteoporosis without current pathological fracture (ICD-10 Code: M81.0)
☐ Age-related osteoporosis with current pathological fracture (ICD-10 Code: M80.0)
☐ Adverse effect of glucocorticoids and synthetic analogues (ICD-10 Code: T38.0X5A)
☐ Other (specify ICD Code) _____________________________
Allergies: ____

ORDER DETAILS FOR PROLIA (DENOSUMAB)

Prolia (Denosumab): 60 mg SC every 6 months

Refills: ☐ x1 ☐ x2 ☐ x3 ☐ x4
Patient is currently taking Calcium/Vitamin D Supplement: ☐ Yes ☐ No

Pre-medications:

☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg PO or IV
☐ Hydrocortisone 100mg IV
☐ Methylprednisolone 125mg IV
☐ Other Pre-medications: _______________
____

Infusion Reaction Protocol:
☐ Pure Infusion Reaction Protocol
☐ Other Reaction Protocol (Please send protocol with order)

ANCILLARY ORDERS

Lab Orders: ____

Additional Orders: ____\

PROVIDER INFORMATION

Practice Name: ___________________________ Provider Name: ___________________________

Signature: ____________________________________ Date: ____________ Time: ____________

Contact Person: __________________ Contact Ph: __________________ Email: __________________

NPI #: ____________ Office Ph: ______________________ Office Fax: ______________________

PURE INFUSION SUITES PREFERRED LOCATION

City: ___________________________ State: ____________________

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REQUIRED DOCUMENTATION FOR EXPEDITED ORDER PROCESSING & INSURANCE APPROVAL

- ☐ Include completed order, signed by provider (page 1)
- ☐ Include patient insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) 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 ☐ No
  - ☐ Calcium level available:
    - ☐ Yes ☐ No Other pertinent information: ______________________________
- ☐ Include labs and/or test results to support diagnosis
- ☐ Other medical necessity: ______________________________

ADDITIONAL REQUIRED INFORMATION

- ☐ **Calcium levels (within 6 months) & DEXA Scan**

Pure Healthcare will provide all necessary documents to the patient's insurance company to confirm eligibility. Our patient-obsessed will inform you if further details are needed. Additionally, we'll discuss financial obligations with the patient and direct them to co-pay assistance options as required.

Please submit BOTH pages & ALL supporting documentation.
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