



159 Fountains Blvd. Madison, MS 39110 Phone:
601.859.8200 Fax: 601.859.8201

**PROLIA (denosumab)
INJECTION**

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Dexa Scan (-2.5 T score or more severe)
***if no -2.5 T score, please send history of fracture documentation*
- Documentation to support primary diagnosis
(Clinical/progress notes, other medications tried & failed, labs, diagnostic tests, etc.)
- Required Labs:** Calcium within 30 days if 1st dose, Calcium within 6 months if subsequent dose

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis ICD-10: Senile Osteoporosis (ICD-10: _____) Paget's disease of bone (ICD-10: _____)
 Glucocorticoid-induced osteoporosis (ICD-10: _____) Other (ICD-10: _____)

J Code: J0897

PROLIA SUBQ ORDERS

Patient Wt. _____ kg

*Patient is currently taking calcium/vitamin D supplementation YES NO

Refills _____

Prolia 60 mg subcutaneous injection every 6 months

*Date of last Prolia injection: _____

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	