Intravene - Prolia Orders (rev 4/2022)

Please fax this form along with a copy of insurance cards
And clinical documentation to 434-455-5531 or call 1-434-947-3900 ext. 3001

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip Code _____
Home Phone # _____
Work Phone # _____
DOB _____ SSN _____
Sex _____Weight _____Height _____
Allergies _____

Primary Ins._____
Secondary Ins._____

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address_____
_____
Physician Phone_____
Physician Fax_____
NPI#_____DEA#_____
State License#_____

****Please fax this form and insurance cards to 434-455-5531****

DIAGNOSIS:ICD-10 (required)

☐ _____ _____
☐ _____ _____
☐ _____ _____

PRIOR TREATMENT HISTORY (IF ANY)

☐ Generic Alendronate
☐ Actonel
☐ Fosamax
☐ Boniva
☐ Other_____

Pertinent Medical History:_____

This patient is currently taking calcium & vitamin D supplements. ☐ yes ☐ no
It is important to advise the patient to take at least 1000mg calcium daily in divided doses and 400 international units of vitamin D daily

☐ **Yes-normal calcium level ** Patient MUST have a normal calcium level to receive Prolia****

STANDARD ORDERS:
Product Name/Strength: Prolia 60 mg pre-filled syringe
Directions: 60mg SC every 6 months for 1 year

ANAPHYLACTIC MEDS AND VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL

Signature, prescribing MD _____ Date _____