immersiv HEALTH

PROLIA® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ M81.0 Age-related osteoporosis without current fractures

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information

☐ Lab Results

☐ List of Medications

☐ Tried & Failed Therapies

☐ Most recent History & Physical

☐ Calcium Levels Drawn Within 60 Days of 1st Injection

☐ Most Recent Bone Density Scan Results

MEDICATION ORDER

☑ Prolia® (denosumab) 60mg subcutaneously every 6 months

COMMENTS: _____

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Immersiv Health to perform lab value clearance at initiation of therapy.
Prescriber responsible for on-going clinical lab monitoring.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)
SUBSTITUTION PERMITTED DISPENSE AS WRITTEN