



eMediateINFUSIONcenter

PROLIA(denosumab)

- New Prescription/Referral
- Prescription Refill

of Refills:

Rx:

Patient Name:

DOB:

PROLIA:

- Administer 60mg via subcutaneous injection Q6 months

Other Orders:

Pre-Medication: (30 mins prior)

- Solumedrol 125mg IVP
- Solu-Cortef 100mg IVP
- Others:

- Tylenol _____mg PO
- 650mg 975mg

- Benadryl _____mg
- 25mg IV
- 50mg PO

ANA Kit Protocol:

- OK to use

Dx:

- Osteoporosis (M81.0)
- Others:

Physician Signature

NPI#:

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information: Phone:
Fax:

Email:
Other:

Office Mailing Address:

- Please include the following*
- Patient demographics
 - Insurance attached
 - Diagnosis (supporting)
 - History and Physical
 - Lab Results
 - Clinical progress notes
 - Medication List
 - Other Test Results