Infusion Solutions Inc.
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PROLIA (Denosumab) ORDER FORM

PATIENT NAME:____ DOB:___________________ WT:_______________ HT:_________________
ALLERGIES:____

DIAGNOSIS

HAS THE PATIENT PREVIOUSLY RECEIVED: Denosumab? ☐ NO ☐ YES LAST DOSE DATE:________________________________
BRAND: ____
DIAGNOSIS: ____ ICD 10 CODE(S): ______________________________

MEDICATION ORDERS

DOSE:
☐ 60 mg SUBQ
☐ Other:____

FREQUENCY:
☐ Every 6 months
☐ Other:____

PREMEDICATION (Given 15 - 30 minutes prior to injection) - not typically indicated:

☐ Medication, dose, and route: ____

This entire order set is valid for 1 year from order date. For a shorter duration, indicate expiration date here: _________________________

STANDARD INJECTION ORDERS

ANCILLARY ORDERS:
- Infusion Reaction Management per Infusion Solutions Protocol.
- Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:
- Monitor vital signs (temp, HR, RR, BP) before and after therapy.
- Observe patient for 15 minutes after completion of therapy.

LABS

LAB ORDERS:
☐ BMP
☐ Phosphorus
☐ Magnesium
☐ Other:_________________________________

LAB FREQUENCY:
☐ Every 6 months at each dose
☐ Other: ____________________________________

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:
- Baseline Calcium Levels.

RECOMMENDED CLINICAL DOCUMENTS (Provide if available):
- Baseline Serum Creatinine.
- Calcium and Vitamin D Supplementation.
- Contraceptive use and Pregnancy test in all females of reproductive potential.
- In patients with Advanced Chronic Kidney Disease, evaluate for CKD-MBD.

SUPPORTING DOCUMENTS:
- Patient demographic information and insurance information.
- Copy of front & back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

____ ____
PRESCRIBER SIGNATURE (substitution permitted) *PRESCRIBER SIGNATURE (dispense as written)*

____ ____________________________
PRINT NAME (first and last) *DATE*