

(denosumab)

PROLIA injection orders



Patient Name _____ DOB _____

Phone _____ M O F

DIAGNOSIS Please provide ICD-10 code

- _____ Age-related osteoporosis **without** current pathological fracture
- _____ Age-related osteoporosis **with** current pathological fracture
- _____ Cancer treatment-induced bone loss due to hormone ablation therapy (CTIBL-HALT)
- _____ (other)

PRE-MEDICATION

- Tylenol 1000mg PO
- Diphenhydramine 25mg PO
- Cetirizine 10mg PO
- _____ (other)

PROLIA ORDERS

DOSAGE	PATIENT WEIGHT
<input checked="" type="radio"/> 60mg SQ, every 6 months	_____ lbs.
	_____ kg
_____ Last Prolia injection date (if applicable)	

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____