

PROLIA® AND XGEVA® (DENOSUMAB) PRESCRIBER ORDER FORM				
Patient Name:			Date of Birth:	
Address:				
Phone:	Height:	<input type="checkbox"/> Inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg
Clinical Information				
Primary Diagnosis Description:			ICD-10 Code:	
Prolia® (Denosumab) Prescription				
<input type="checkbox"/> Prolia® (Denosumab) 60mg injected subcutaneously in the upper arm, upper thigh, or abdomen by a healthcare professional once every 6 months. Refill x 1 year.				
Xgeva® (Denosumab) Prescription				
<input type="checkbox"/> Xgeva® (Denosumab) 120mg every 4 weeks injected subcutaneously in the upper arm, upper thigh, or abdomen by a healthcare professional. Refill x 1 year. <input type="checkbox"/> Xgeva® (Denosumab) 120mg every 4 weeks with additional 120mg doses on days 8 and 15 of the first month of therapy. Inject subcutaneously in the upper arm, upper thigh, or abdomen by a healthcare professional. Refill x 1 year.				
Ancillary Orders				
Anaphylaxis Kit If this is a 1 st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1 st dose? <div style="margin-left: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN. Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement. 0.9% Sodium Chloride 500 mL (> 30 kg) or 250mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. </div>				
Lab Orders <input type="checkbox"/> No labs ordered at this time. <input type="checkbox"/> Other: _____				
Skilled nurse to assess and administer as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.				
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>				
Prescriber Signature: _____			Date: _____	
Prescriber Information				
Prescriber Name:		Phone:	Fax:	
Address:		NPI:		
City, State:	Zip:	Office Contact:		
Fax completed form, insurance information, and clinical documentation to:				
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