PROLIA® AND XGEVA® (DENOSUMAB) PRESCRIBER ORDER FORM

Patient Name:		**Date of Birth:**		
Address:				
Phone:	**Height:**	☐ Inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Prolia® (Denosumab) Prescription

☐ 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

☐ Xgeva® (Denosumab) 120mg every 4 weeks injected subcutaneously in the upper arm, upper thigh, or abdomen by a healthcare professional. Refill x 1 year.

☐ 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 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

- 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.

Lab Orders

☐ No labs ordered at this time.

☐ 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 certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

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:

