OKLAHOMA INFUSION SERVICES

Prolia Order Form

Please fax form to: 405-726-9849

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ M80.0 Age-Related Osteoporosis with Current Pathological Fracture
☐ M81.0 Age-Related Osteoporosis without Current Pathological Fracture
☐ M81.8 Other Osteoporosis without Current Pathological Fracture
☐ Other: Code: _____ Description: _____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: _____ lbs / _____ kg ☐ Patient Height: _____ in / _____ cm
☐ Allergies: _____
☐ Therapies Tried and Failed: _____
☐ Date of last Prolia injection: _____ ☐ Clinical note for last Prolia injection attached? ☐ Yes ☐ No
☐ Does patient have history of hypersensitivity to Prolia or any ingredient of Prolia? ☐ Yes ☐ No
☐ Is patient currently taking Calcium/Vitamin D supplement? ☐ Yes ☐ No Date of last Calcium/Vitamin D: _____
☐ Is patient currently taking XVEGA? ☐ Yes ☐ No
☐ Is patient pregnant or potentially pregnant? ☐ Yes ☐ No
☐ Date of last DEXA scan: _____ ☐ Clinical note for last DEXA scan attached? ☐ Yes ☐ No

Lab Orders

☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ Pregnancy Test
☐ Other _____

Lab Orders to be done by

☐ Oklahoma Infusion Services
☐ Referring Provider

Prescription Information

☐ Prolia ☐ Dose: 60mg ☐ Frequency: every 6 months

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus
☒ Notify supervising physician and ordering provider
☒ Solu-Cortef 100mg SIVP signs of adverse reaction
☒ Benadryl 25mg SIVP for hives or bronchial inflammation
☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Oxygen 2-5L nasal cannula
☒ Albuterol 2.5mg inhaled PRN for chest tightness
☐ Other: _____

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

_____ _____

Prescriber's Signature: **Date:**

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

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