REVITALIZE
INFUSION CENTER

Prolia®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Age-related Osteoporosis without current fracture ICD-10 Code: M81.0

☐ Age-related Osteoporosis with current fracture ICD-10 Code: M80.0

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
  - Currently receiving Calcium/Vitamin D supplementation:
    ☐ Yes ☐ No ☐Other: _____
- Required Information:
  - DXA scan within 2 years
  - Recent serum calcium within 3 months

Height: _____

Weight: _____

Prolia (denosumab) Orders:

☐ Administer 60 mg subcutaneously every 6 months for one year (2 doses)

☐ Substitute with the preferred plan biosimilar – Stoboclo 60 mg SUBQ * 2 doses – if required by insurance plan (i.e. BCBS)

☐ Date of last Prolia Injection: _____ ☐ New Start

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

Please fax the completed order form and all other requested information to: 601-714-1569

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus