Infusion Associates
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Grand Rapids, MI 49525
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Prolia ORDER

*****Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

Does patient have a diagnosis or history of any of the following (check all that apply)?:

- ☐ Hypocalcemia
- ☐ History of hypoparathyroidism
- ☐ Thyroid or parathyroid surgery
- ☐ Severe renal impairment (CrCl<30)
- ☐ Malabsorption syndromes
- ☐ Recurrent UTI
- ☐ Recent tooth extraction or jaw surgery

☐ **NO** the patient does **NOT** have history of any of the above

Diagnosis : ☐ Age related osteoporosis without current pathologic fracture M 81.0
☐ Age related osteoporosis with current pathologic fracture M80.0
☐ Other: please specify:_____

Prolia (denosumab) 60 mg Subcutaneous every 6 months

Lab work required within 2 months of appointment.
Labs drawn on:____/_____/____

Serum Calcium:_____

Contraindicated in patients with hypocalcemia

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____ **Fax Number:** _____