Fax: 614-929-7199/ Phone: 614-929-3349/ Email: Info@infuseoneohio.com

(denosumab)

INFUSE ONE OHIO

PROLIA injection orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Age-related osteoporosis ***without*** current pathological feature
- ☐ _____ Age-related osteoporosis ***with*** current pathological feature
- ☐ _____ Cancer treatment-induced bone loss due to hormone ablation therapy (CTIBL-HALT)
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ *(other)*

PROLIA ORDERS

DOSAGE

☐ 60mg SQ, every 6 months

_____ Last Prolia injection date *(if applicable)*

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

ORDERING PROVIDER

Provider NPI: _____ Phone_____ Fax _____

Provider Name _____

Provider Address _____

Signature _____ Date_____