Cumberland Vital Care

Fax Referral To:

(931) 456-4857

Direct Phone: (931) 456-0680

PROLIA ORDER FORM

Date:	ICD-10 Code: _____
Patient Name:	Allergies: _____
Date of Birth:	Weight: _____lbs OR _____kg

Therapy Status	Provider Information
New Start ☐ Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER

☐ Prolia	✓ Administer Prolia 60mg subcutaneously every six months. **Hypocalcemia should be corrected before initiating Prolia. Hypocalcemia may worsen, especially in patients with renal impairment. Patients should supplement adequately with calcium and vitamin D. **	**Refills x one year from date of signature unless indicated below.** ☐ _____ Refills	**Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:** ✓ Serum calcium within 60 days prior to each dose.

PRE-MEDICATIONS

Oral	IV
Acetaminophen: ___325mg ___500mg __650mg	Dexamethasone: ___4mg ___8mg
Loratadine: 10 mg	Diphenhydramine: ___25mg __50mg
☐ Cetirizine: 10mg	☐ Famotidine: ___20mg ___40mg
☐ Diphenhydramine: ___25mg ___50mg	☐ Methylprednisolone 125mg
☐ Famotidine: ___20mg ___40mg	☐ Hydrocortisone 100mg
☐ Ibuprofen: ___200mg ___400mg ___600mg	☐ Ondansetron: ___4mg ___8mg
☐ Ondansetron: ___4mg ___8mg	☐ Other_____
☐ Other_____	

LAB ORDERS (Please indicate any labs to be drawn and frequency)	OTHER REQUIRED DOCUMENTATION
Surveillance lab ordering, and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Ofice Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written:	Substitution Allowed:
_____ _____ Prescriber Name Date	_____ _____ Prescriber Name Date

V 8.8.22