LINCOLN Health System

OUTPATIENT INFUSION CENTER

Phone: 931-438-1100
Fax: 1-931-438-1219

PROLIA (DENOSUMAB) ORDER FORM

Patient name: _____ DOB: _____ Sex :( ) Male ( ) Female

SSN:_____ HT: _____ WT: _____ Allergies:_____

Street Address_____ City/State/Zip _____

Home Phone #: _____ Work #: _____ Cell #: _____

Insurance Information:

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

Physician Information:

Physician's Name:_____ Referral Contact Name: _____ Phone: _____

Address:_____City/State/Zip_____

DEA#:_____ NPI #:_____ Fax #: _____

State License #: _____

Statement of Medical Necessity

Primary Diagnosis: (ICD-10 Code plus Description)_____

Date of Diagnosis: _____

Access: Does the patient have venous access? ☐Yes ☐ No If Yes, what type? _____

Orders:

PROLIA (DENOSUMAB) 60mg/ml, SQ once every 6 months X 1 year

Include copies of the following with the order:

- BUN, Creatinine, and Calcium must be check within the last 30 days, otherwise the hospital will collect prior to infusion.
- Bone Density/DEXA Scan within the last 2 years, otherwise one will be performed prior to the date of service
- Office notes supporting the diagnosis of Osteoporosis/Osteopenia dated within the last 2 years
- H&P dated within the last 2 years
- Prior/current medications used to treat the diagnosis of Osteoporosis/Osteopenia must be documented in patient's medical record. Examples: Oral calcium, Vitamin D

Labs: BUN and Creatinine and Calcium (if previous results not provided within last 30 days)

Physician's Signature _____**Date**_____ **Time:**_____

Fax completed form to the Outpatient Infusion Center at 1 (931) 438-1219.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.