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

(denosumab)

INFUSE ONE

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

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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