Opelousas GENERAL HEALTH SYSTEM

Outpatient Infusion Clinic – Prolia Order

Patient Name: _____ DOB:_____

Allergies: _____

Medication: **Prolia** Dosage: **60 mg** Frequency: **SQ every 6 months** Refill**: x1**

Prior Osteoporosis Therapy:____Generic alendronate ____Fosamax (alendronate sodium)
____Actonel (risedronate sodium) ____Boniva (ibandronate sodium)

Reason for stopping prior osteoporosis therapy(s): _____

Diagnosis:

- ☐ M81.0 Age-related osteoporosis without current pathological fracture
- ☐ M80.0 Age-related osteoporosis with current pathological fracture
- ☐ Other (specify ICD-10 code)_____

Baseline osteoporosis diagnostic T-score: _____ (-2.5 & lower) Date: _____
Current diagnostic T-score: _____ Date: _____ FRAX score_____

Circle Yes (Y) or No (N)

Y/N Hypocalcemia, hypoparathyroidism, thyroid surgery, parathyroid surgery, excision of small intestine, renal impairment, dialysis (*any of these conditions require a phosphorus and magnesium level drawn within 14 days of infusion appointment* – **must attach lab work if indicated**)

Y/N Patient history of Cancer and has taken or is currently taking an aromatase inhibitor
If yes, name of aromatase inhibitor & cancer diagnosis w/historical date_____

Y/N Patient currently taking Calcium + Vitamin D, w/continued use discussed and documented in patient's medical record

Y/N Patient previously given Prolia and still high risk for fracture due to advancing age
BMD returns to baseline within one year if Prolia is discontinued

Y/N Patient previous had a non-pathological fracture of _____ (list location)
Automatically qualifies patient for use of Prolia. **Attach Radiology report for fracture.**

Physician (Printed) Name:_____

Signature **Date** **Time**

Fax completed form to 337-594-1290; MUST also include:

- OGHS Outpatient Infusion Clinic Patient Referral Form
- Comprehensive Metabolic Panel needed within 30 days of appointment

Please call us with any questions at (337) 678-4856