

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX Handwritten forms will not be accepted.

PATIENT INFORMATION				
Name:				DOB:
Allergies:		Date of Referral:		
REFERRAL STATUS				
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal				
INFUSION OFFICE PREFERENCES (Optional)				
Preferred Location* <input type="checkbox"/> Mattoon <input type="checkbox"/> Effingham				
<small>*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.</small>				
Diagnosis and ICD 10 CODE				
<input type="checkbox"/> Osteoporosis in women or men at high risk of developing fracture		ICD 10 Code: M81.0		
<input type="checkbox"/> Other: _____		ICD 10 Code: _____		
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)				
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> DEXA scan results and/or FRAX score (must be within 2 years) <input type="checkbox"/> Vit D, BMP within 45 days of dose <small>*Patient may be required to submit a pregnancy test prior to treatment</small>		<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis (must be within 1 year) <input type="checkbox"/> Calcium drawn on _____ (must be within the last 2 weeks) and noted to be WNL and results sent; the patient is cleared to receive the drug		
List Tried & Failed Therapies, including duration of treatment:				
1)				
2)				
3)				
MEDICATION ORDERS				
Dosing Wt for Calculations	Ht:	Wt (in kg):	BMI:	
Biologic Injection Order				
Medication	Dosing	Route	Rate of Infusion	Dates of administration
<input type="checkbox"/> J0897 Prolia	60 mg	SQ	N/A	X 2 dose**
<input type="checkbox"/> J0897 Prolia	_____	SQ	N/A	X 1 dose**
**Clinical monitoring of calcium, phosphorus, and magnesium is highly recommended in patients with severe renal impairment. Adequately supplement all patients with Calcium and vitamin D.				
ADDITIONAL ORDERS / INFORMATION				
PRESCRIBER INFORMATION				
Prescriber name :				
Office Phone:		Office Fax:		Office Email:
Prescriber Signature:			Date:	Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:

Fax Completed Form and all documentation to:

☐ MATTOON

1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM

901 Medical Park Dr. Ph. 217-342-7500
Suite 201 Fax 217-342-7499
Effingham, IL 62401

Effective Date: 5/12/23

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INFUSION ORDERS - PROLIA (DENOSUMAB)

Clinics Scan to: Physician Orders