



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 *Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.				
Diagnosis and ICD 10 CODE				
<input type="checkbox"/> Osteoporosis in women or men at high risk of developing fracture <input type="checkbox"/> Other: _____		ICD 10 Code: M81.0 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 *Patient may be required to submit a pregnancy test prior to treatment		<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:

Contact us with questions at:
Fax Completed Form and all documentation to:

Fax Completed For

MATTOON

1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579

□ EFFINGHAM

901 Medical Park Dr.
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Effingham, IL 62401

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INFUSION ORDERS - PROLIA (DENOSUMAB)

Clinics Scan to: Physician Orders