

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.