Midnight Sun ONCOLOGY

Prolia (denosumab) Order Form

Please include recent labs and last two office visit notes

Please fax to 907-746-7798 - Clinic Phone Number: 907-746-7771

PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: ☐M ☐F	Weight:
Patient Status: ☐ New to therapy ☐ Continuing therapy	Next due date (if applicable):

PHYSICIAN INFORMATION

Physician's Name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office phone:	Email:	
Office contact:	Office fax:	

DIAGNOSIS INFORMATION

☐ Osteoporosis ICD 10 (M81.0)	Year of Diagnosis:
☐ Other (specify):	Year of diagnosis:

INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

Primary Insurance:	ID#	Secondary Insurance:	ID#

PRESCRIPTION INFORMATION (requires new order every 12 months)

Medication may be substituted with payer-preferred brand, generic, or biosimilar equivalent per authorization and institutional formulary

Prolia:

☐ Administer 60mg/ml SQ once every 6 months

Vital signs per clinic protocol

Infusion reaction/Hydration Management per clinic protocol

Signature (required)

PHYSICIAN SIGNATURE DATE