sage infusion

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(denosumab)

PROLIA injection orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Age-related osteoporosis ***without*** current pathological fracture
- ☐ _____ Age-related osteoporosis ***with*** current pathological fracture
- ☐ _____ Cancer treatment-induced bone loss due to hormone ablation therapy (CTIBL-HALT)
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ *(other)*

PROLIA ORDERS

DOSAGE

- ◉ 60mg SQ, every 6 months

_____ Last Prolia injection date *(if applicable)*

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____