

**Patient Information**

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
Last infusion date (if applicable):		_____	
Is the patient pregnant, planning a pregnancy or nursing:		Yes	No
Does the patient need interpreter services:		Yes	No

**Provider Information**

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip:

**ICD-10 CODE**

M81.0 Age-related osteoporosis without current pathological fracture	T38.0X5A Adverse effect of glucocorticoids and synthetic analogues
M81.8 Other osteoporosis without current pathological fracture	Other: _____

**Medication Order**

<b>Prolia</b> (denosumab)	<b>Dose:</b> 60 mg SC every 6 months	<b>Patient is currently taking Calcium/Vitamin D Supplement:</b> Yes No
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**Documentation Required (Note: Send all labs, must include specific labs listed here)**

Labs (Ca (within 6 months) and DEXA Scan results or evidence of Osteopenia)

Insurance Card (front and back)	Current Medications	History/Progress Notes
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**Special Instructions (Prior therapy, treatment dates, and reasons for d/c)**

<b>Provider Name</b>	<b>Provider Signature</b>	<b>Date</b>
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Order Expiration Date (mm/dd/yy): \_\_\_\_\_ (If not indicated order will expire one year from date signature) Check here if this is a stat order

**Patient Information**

Patient Name:	DOB:	Sex:	M	F	Fasting:	Y	N
Patient Home Phone:	Patient Cell Phone:						
Emergency/Alternate Contact Name:	Emergency/Alternate Contact Phone:						

**Lab Test (Please circle or write in ICD-10)**

ALT	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	HIV VIRAL LOAD	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20
AST	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgE	J45.4, J45.3, L50.9, J45.40, J45.50
HEPATIC FUNCTION PANEL	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgG	G35, G36.0
BASIC METABOLIC PANEL	I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9	IMMUNOGLOBULIN QUANT IgG, IgM, IgA	G35, G36.0
CALCIUM	M81.0, M81.8	IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE	G35, G36.0
CBC (INCLUDES DIFF/PLT)	I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1	IRON, TIBC, FER PNL	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
CBC (H/H, RBC, WBC, PLT)s	I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1	LIPID PANEL	Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2
COMP METABOLIC PANEL	I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9	MAGNESIUM	I10, Z79.899, R25.2, E83.42, Z00.00
CREATININE	M81.0, M81.8, G35	PSA	R97.20, C61, N40.1, Z12.5, N40.0
C-REACTIVE PROTEIN (CRP)	R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50	PROTHROMBIN TIME-INR	Z79.01, I48.91, I48.0, Z51.81
FERRITIN	D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9	TRANSFERRIN SATURATION	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
G6PD	M1A.9XX0, M1A.9XX1	QUANTIFERON TB GOLD	Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90
GROWTH HORMONE	E22, C7A.1, E34	TSH	E03.9, I10, E03.8, R53.83, E06.3, E05.00
HBSAG CONFIRMATION	Z11.3, Z36.9, Z20.2, Z11.59, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	URIC ACID	M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1
HEMOGLOBIN & HEMATOCRIT	D50.9, D64.9, D50.0, D63.1, N18.9	VIT B12/FOLIC ACID	M89.49, E53.8, R53.83, F41.8, F41.9, E05.00
HEMOGLOBIN A1C	E11.9, E11.65, R73.01, Z00.00, I10	VIT D 25- HYDROX	E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8
HEP B SURF AG	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	Miscellaneous Labs Not Listed (Write In)	
HIV 4TH GEN	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20		
HIV 1/2 AB DIFF	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20		

**Frequency**

Prior to each dose	Yearly	Other: Please Specify Below
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	

Provider Name

Provider Signature

Date

Provider Phone