

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

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		
DIAGNOSIS AND ICDE 10 CODE		
<input type="checkbox"/> Osteoporosis	ICD 10 Code: M81.0	
<input type="checkbox"/> Other:	ICD 10 Code: _____	
Is patient currently taking required Calcium and Vitamin D Supplementation <input type="checkbox"/> Yes <input type="checkbox"/> No MANDATORY: All patients must receive adequate calcium and vitamin D supplementation unless hypercalcemia is present.		
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)		
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number <input type="checkbox"/> Clinical/Progress notes (must be within 1 year)	<input type="checkbox"/> Labs and tests supporting primary diagnosis <input type="checkbox"/> DEXA Scan results and/or FRAX score (must be within 2 years) <input type="checkbox"/> Calcium Level, Date and Result:	
List of tried and failed therapies, including duration of treatment: _____		
MEDICATION ORDERS		
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____		
Dosing	<input type="checkbox"/> J0897 Prolia 60mg SubQ injection every 6 months	
** 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.		
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses		
ADDITIONAL ORDERS/INFORMATION		
<input type="checkbox"/> Calcium Level to be drawn prior to each injection *HOLD PROLIA IF CALCIUM LEVEL IS LESS THAN 8.5*		
PRESCRIBER INFORMATION		
Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – PROLIA (DENOSUMAB)