

**\*Please include demographics, most recent H&P, most recent clinical notes, bone density scan results, medication list and lab results\***  
**\*INCLUDE PATIENT'S MOST RECENT SERUM CALCIUM LEVEL\***

### PATIENT INFORMATION

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M / F  
Street Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
City/ State/ Zip: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_  
Allergies: \_\_\_\_\_

### STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis (ICD-10 Code plus Description):

M81.0 Osteoporosis  Other (Please Specify) \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

### Prolia Order

- Prolia 60 mg Subq, every 6 months, for one year
- All patients receiving Prolia injections at Hunt Regional Infusion Clinic should have their calcium levels monitored within the last 30 days to ensure the patient's correct serum calcium level is within normal limits (WNL), prior to the administration of Prolia.
    - Hunt Regional Infusion Clinic may draw a (BMP) Basic Metabolic Panel prior to injection, as needed.
    - If the patient has a serum calcium level (WNL) in the past 30 days, prior to the injection, it is not necessary to redraw the lab.

**"Pharmacy law may permit pharmacists to substitute a less expensive FDA-approved generically equivalent medication or biosimilar for a brand-name medication or prescribed biologic unless the practitioner indicates otherwise by writing "brand necessary" or "brand medically necessary" on the prescription."**

### PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Prescriber Signature Below:

\_\_\_\_\_ MD DO PA NP Date: \_\_\_\_\_

**Fax completed form to Hunt Regional Infusion Center at 903-455-8773. Please include copies of all patients' current insurance cards to expedite benefit verification.**