



Phone: 608-690-7210
Fax: 608-807-5179
www.MySmartInfusion.com

Prolia (Denosumab) And Biosimilar

Subcutaneous Injection Order Form

Location

- Eau Claire Weston
 Middleton Onalaska

Patient Information

Patient Name: _____ DOB: _____ M F

Allergies: _____

New Treatment Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

- Age related Osteoporosis without pathological fracture ICD 10 Code: M81.0
 Age related Osteoporosis with current pathological fracture unsp. site ICD 10 Code: M80.00XA

Required Tests

DEXA Scan (within 12 months & attach results)

Required Labs

Serum Creatinine, Serum Calcium
(within 6 months & attach results)
Pregnancy Test Status & Date: _____

Pre-Medication Orders

Acetaminophen (Tylenol) 500mg 650mg 1000mg PO
Diphenhydramine (Benadryl) 25mg 50mg PO IV
Methylprednisolone (Solu-Medrol) 125mg IV
Ondansetron (Zofran) 4mg PO IV
Other: _____ Route: _____
Dose: _____ Frequency: _____

Medication Order

Prolia

Biosimilar:
 Jubbonti (denosumab-bbdz)

Will substitute Prolia for biosimilar or referenced product based on insurance and availability.
OR
 Dispense as written
Refill x12 months unless otherwise noted:

Dosage – Subcutaneous Injection
 60mg

Frequency
 Every 6 months

Adverse Reaction Management & Nursing Orders

Full protocols are available for review at mysmartinfusion.com or upon request.

<input checked="" type="checkbox"/> Administer the following emergency medications per Smart Infusion Therapy Services protocol: <input checked="" type="checkbox"/> Acetaminophen 650mg PO, <input checked="" type="checkbox"/> Diphenhydramine 25mg-50mg PO or IV <input checked="" type="checkbox"/> Ondansetron 4mg IV <input checked="" type="checkbox"/> Sodium Chloride 0.9% 1000mL IV <input checked="" type="checkbox"/> Methylprednisolone 125mg IV <input checked="" type="checkbox"/> Albuterol Sulfate 2.5mg nebulized <input checked="" type="checkbox"/> Oxygen 1-6LPM continuous flow <input checked="" type="checkbox"/> Epinephrine 0.3mg/0.3mL IM <input type="checkbox"/> Other: _____	<input checked="" type="checkbox"/> Manage VAD per protocol: <input checked="" type="checkbox"/> Start/Access and Discontinue PIV/CVC <input checked="" type="checkbox"/> Flush with NS and/or Heparin per protocol based on line type <input checked="" type="checkbox"/> Other: _____
---	--

Required Documents

Patient Demographic Sheet
 H & P within the past 6 months
 Current Medication List
 Clinical & Progress Notes (including last infusion note)
 Copy of Insurance Card (Front/Back)

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____