hŎǘƶōŜ 2024

Ascend
INFUSION CENTERS

Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

PROLIA ORDER

☐ **New Start** ☐ **Maintenance: Last Dose Given_____________**

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies ☐ NKDA ☐ Allergies: ____

Height: _________________________ Weight: _________________

Indication:
☐ M81.0 Senile Osteoporosis w/o fracture
☐ M80.___ Age-related Osteoporosis with current fx.
☐ M81.8 Other Osteoporosis without current fx
☐ Other ____

DOSAGE ORDERS:
☐ 60mg SQ every 6 months

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:
☐ Face Sheet / Patient Demographics
☐ Insurance card(s) – copy of front & back
☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
Most Recent Labs (within last 4-8 weeks) – Required:
☐ CBC ☐ CMP ☐ TB ☐ Hep B Other: ____