FirstHealth OF THE CAROLINAS

7096.08.16150.01 Sunset Date: 6/2024

OP Prolia Referral

Place Patient Label Inside This Box

***** This section refers to the entire plan. If individual orders need a different interval, please indicate in each section below*****

Version 6/2021

Date of Infusion: ______________________________

Lead Physician ______________________________

Patient Name: ______________________________

Date of Birth: ______________________________

Patient SSN (if available): ______________________________

Contact Number: ______________________________

Insurance Name: ______________________________

Policy Number: ______________________________

Secondary Insurance: ______________________________

Policy Number: ______________________________

Diagnosis Code: ______________________________

Precertification: ☐ Initiated ☐ Complete

Diagnosis Code Description: ______________________________

Location to be Performed:
- ☐ Moore Regional Hospital (MRH)
- ☐ Montgomery Memorial Hospital (MMH)

Interval __________ Day ______ of every ______ month

Next Due Date ______________________________

Minimum Separation _______ days / weeks (circle one)

Duration: ☐ Until discontinued ☐ ____ Treatments
☐ Until ______________________________

Medications	Interval	Duration
☐ denosumab (PROLIA) syringe 60 mg 60 mg, subcutaneous	________	________

Nursing Orders		
☐ Nursing communication Please ensure patient is taking Calcium 1200mg Daily along with Vit D3 2000IU Daily	________	________

For Scheduling Fax Forms to: (910) 715-1177.

Provider Signature: ______________________________ **Date:** ____________ **Time:** ____________

* May be used as EPIC Downtime Form