



WWW.VASCOINFUSION.COM  
 PH: 602-346-0204 FAX: 877-637-6691

- New Referral   
  Restart   
  Medication/ Order Change (New Order Required)   
  Benefits Verification Only   
  D/C Infusions \*indicate name of drug(s)

*Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.*

**PATIENT INFORMATION**

**PHYSICIAN INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 DOB: \_\_\_\_\_ SS# \_\_\_\_\_  
 Phone # \_\_\_\_\_  
 Email: \_\_\_\_\_

Referring Physician: \_\_\_\_\_  
 Practice Address: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_  
 Contact Phone # \_\_\_\_\_ Contact Fax # \_\_\_\_\_  
 NPI / TIN: \_\_\_\_\_

**PROLIA MEDICATION ORDERS**

- Dosing: **60 mg SC every 6 months**      Refills: \_\_\_\_\_  
 Patient is currently taking Calcium/Vitamin D Supplement  Yes  No     
 Has the patient had any fractures?  Yes  No

**INDICATION/DIAGNOSIS**

**NOTES (ADDITIONAL INFO)**

- Osteoporosis Steroid induced  
 Osteoporosis Senile Osteoporosis  
 Postmenopausal  
 Other (please specify in notes)

**\*ICD-10 \_\_\_\_\_ required**

\_\_\_\_\_  
 Referring Physician's Signature

\_\_\_\_\_  
 Date

**REQUIRED DOCUMENTATION**

- Recent Office notes (along with any therapies tried and outcomes)   
  Current Medication List   
  History and Physical Report  
 Lab Results   
  Insurance Cards (front and back)   
  Demographic Sheet

**ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)**

- Serum Calcium (w/in 1year)   
  DEXA Results (w/in 2 years)   
  Vitamin D 25-OH (if available)

**APPOINTMENT DATE & TIME:** \_\_\_\_\_