PROLIA (DENOSUMAB) Referral Order Form

FAX (877) 637-6691

VASCO INFUSION

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

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

PROLIA MEDICATION ORDERS

☐ Dosing: **60** mg SC every **6** months

Patient is currently taking Calcium/Vitamin D Supplement ☐ Yes ☐ No

Has the patient had any fractures? ☐ Yes ☐ No

INDICATION/DIAGNOSIS

☐ M81.0 Age-related osteoporosis without current pathological fracture
☐ M81.8 Other osteoporosis without current pathological fracture
☐ Other (please specify in notes)

***ICD-10** _____ **required**

_____ _____
Referring Physician's Signature Date

NOTES (ADDITIONAL INFO)

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 (within 3 months of each dose) ☐ DEXA Results (w/in 2 years) ☐ Vitamin D 25-OH (if available)

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY