FUSE INFUSION
175 Memorial Highway. Suite 1-1
New Rochelle, NY
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914-460-4571

(denosumab)

# PROLIA injection orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

## DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Age-related osteoporosis ***without*** current pathological feature
- ☐ _____ Age-related osteoporosis ***with*** current pathological feature
- ☐ _____ Cancer treatment-induced bone loss due to hormone ablation therapy (CTIBL-HALT)
- ☐ _____ _____ *(other)*

## PRE-MEDICATION

- ☐ Tylenol 1000mg IV
- ☐ Diphenhydramine 25mg IV
- ☐ Cetirizine 10mg IV
- ☐ _____ *(other)*

## PROLIA ORDERS

**DOSAGE**

◉ 60mg SQ, every 6 months

_____ Last Prolia injection date *(if applicable)*

**PATIENT WEIGHT**

_____ lbs.

_____ kg

## NOTES

## ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____