PINNACLE NEUROLOGY & INFUSION

Prolia Injection Order Form

Patient Name: _________________________ DOB: __________________
Allergies: ____ / NKDA
Height: _________ (in/cm) Weight: _________ (lb/kg)

ICD-10 Code for DX: _____________________

Prolia Injectable 60mg **Injection to be administered subcutaneously:**

☐ Once every 6 months

Has the patient received this medication before: ☐ No ☐ Yes, previous:___________

Prescriber Signature:____
Prescriber Printed Name: _____________________NPI Number:___________
Date: __________Phone:__________________ Fax: _________________

Prior Authorizations: *All medications require a prior insurance authorization. These authorization may take up to* ***30 days*** *for approval. Patient's are responsible for all insurance deductibles, co-payments and co-insurance coverage. Please have the patient reach out to their insurance companies to discuss insurance coverage.*

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