MUNSON HEALTHCARE

Form 10132 (02/24)

AUTHORIZATION IS GRANTED TO DISPENSE AND ADMINISTER AN ALTERNATE DRUG PRODUCT ACCEPTABLE TO THE MEDICAL STAFF'S PHARMACY COMMITTEE UNLESS THE DRUG PRODUCT IS SPECIFICALLY CIRCLED.

Every 6 months x 2 doses. | ☐ Office note attached that supports the reason for Prolia (required).

Allergies/Reactions:

DEXA Scan T Score:_____Date of Scan:_____Region of Scan (e.g., lumbar spine, femoral neck): _____

Patient is taking calcium supplementation: ☐ yes ☐ no
(Recommendation: Calcium 1000 mg + Vitamin D 400 International Units per day and ≥50 years old: Calcium 1200-1500 mg + Vitamin D 800 International Units per day)

DIAGNOSIS (Complete One Box Below)

☐ **Treatment of postmenopausal osteoporosis in women (M81.0) PLUS** (complete one option below)

- ☐ A. Failure of other osteoporosis therapy
  - Drug Failed:
  - Treatment Dates: From (mm/yy)_____to (mm/yy)_____.
  - Reason for Failure:
- ☐ B. Intolerance of other osteoporosis therapy
  - Drug to which patient is intolerant:
  - Treatment Dates: From (mm/yy)_____to (mm/yy)_____.
  - Reason for Intolerance:
- ☐ C. Multiple risk factors for future fractures
  - Risk Factors:
- ☐ D. History of osteoporotic fracture
  - Date and type of fracture:
- ☐ E. Diagnosis of Chronic Kidney Disease
  - ☐ Stage III (N18.3)
  - ☐ Stage IV (N18.4)
  - ☐ Stage V (N18.5)

☐ **Treatment of osteoporosis in men (M81.0) PLUS** (complete one option below):

- ☐ A. Failure of other osteoporosis therapy
  - Drug Failed:
  - Treatment Dates: From (mm/yy)_____to (mm/yy)_____.
  - Reason for Failure:
- ☐ B. Intolerance of other osteoporosis therapy
  - Drug to which patient is intolerant:
  - Treatment Dates: From (mm/yy)_____to (mm/yy)_____.
  - Reason for Intolerance:
- ☐ C. Multiple risk factors for future fractures
  - Risk Factors:
- ☐ D. History of osteoporotic fracture
  - Date and type of fracture:
- ☐ E. Diagnosis of Chronic Kidney Disease
  - ☐ Stage III (N18.3)
  - ☐ Stage IV (N18.4)
  - ☐ Stage V (N18.5)

☐ Treatment of bone loss in women receiving current adjuvant aromatase inhibitor therapy for breast cancer (must check all 3)

- ☐ A. Breast cancer (C50.__ __ __)
- ☐ B. Osteopenia (M85.80)
- ☐ C. Current use of aromatase inhibitor (Z79.811)

☐ Treatment of bone loss in men receiving androgen deprivation therapy for nonmetastatic prostate cancer (must check all 3)

- ☐ A. Prostate Cancer (C61)
- ☐ B. Osteopenia (M85.80)
- ☐ C. Long term (current) use of other medications, androgen deprivation therapy (Z79.899)

☐ Treatment of glucocorticoid-induced osteoporosis (initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone and expected to remain on for at least 6 months) PLUS (complete one option below)

- ☐ A. Failure of other osteoporosis therapy
  - Drug Failed:
  - Treatment Dates: From (mm/yy)_____to (mm/yy)_____.
  - Reason for Failure:
- ☐ B. Intolerance of other osteoporosis therapy
  - Drug to which patient is intolerant:
  - Treatment Dates: From (mm/yy)_____to (mm/yy)_____.
  - Reason for Intolerance:
- ☐ C. Multiple risk factors for future fractures
  - Risk Factors:
- ☐ D. History of osteoporotic fracture
  - Date and type of fracture:

LAB ORDERS (unless otherwise specified): Calcium level within one month of each treatment

HOLD treatment & notify physician if:

- Serum calcium (corrected calcium if albumin available) < 8 mg/dL
  (Corrected Ca = [0.8 x (4 - patient's albumin)] + serum Ca level)
- Ionized calcium < 1 mmol/L

Monitor:

- For hypocalcemia (increased risk for CrCl ≤ 30mL/min)
- For arthralgias/myalgias
- For osteonecrosis of jaw

MEDICATION	DOSAGE	ADMINISTRATION INSTRUCTIONS	FREQUENCY
Denosumab (Prolia) **J code: J0897**	**60 mg**	Subcutaneous (Administer upper arm, upper thigh, or abdomen)	Every 6 months

IF PATIENT HAS A HYPERSENSITIVITY REACTION, BEGIN HYPERSENSITIVITY PROTOCOL

Reference: Prolia Prescribing Information

The provider's full signature(s) is to follow the order

Patient Name:

Date of Birth:

_____

Provider Signature **Date** **Time**

_____

Provider Printed Name