Northwest Rheumatology Associates, P.C.
9555 SW Barnes Road - Suite 150 – Portland, Oregon 97225
Telephone: (503) 297-3384 - Fax: (503) 297-0863
www.nwrheumatology.org

PROLIA ORDER

Patient Name: ________________________ DOB: _________ Date: ________

Patient demographics, (address, phone) ☐

Copy front and back of all insurance cards ☐

Copy of most recent DEXA scan ☐

The dose of Prolia is <u>60mg SQ every 6 months</u>

Prior to injection confirm the following;

<u>Completed</u>	**<u>Not required</u>**	
☐	☐	**<u>Serum calcium</u>** has been checked within 6 months and is within normal range
☐	☐	**<u>Vitamin D</u>** has been checked within 6 months and is greater than 30ng/ml
☐	☐	**<u>Complete dental exam within 3 months of treatment</u>**

ICD-10 Code: ____________________

CPT Code: J0897

Expires one calendar year from date or: ______________________________

Ordering physician signature: ____

Ordering physician printed name: _____________________________________

Ordering physician phone number: ____________________________________

Ordering physician fax number: _______________________________________

Please note all boxes must be checked off for us to schedule your patient for treatment. *Please fax this information to (503) 297-0863 Attn: Patient Resource Team*
Please call with any questions at (503) 297-3384