Denosumab (Jubbonti, Prolia)

Provider Order Form rev. 2/11/2026

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

☐ M80. ___: Osteoporosis w/ pathological fx ☐ M81. ___: Osteoporosis w/o pathological fx

☐ Other: Description:

REQUIRED INFORMATION

☑ Last serum Ca+ drawn on _____ Result: _____ (please send with order).

☐ Ok to use this lab result for Denosumab injection.

THERAPY ADMINISTRATION

☐ Administer Denosumab (Prolia) or Denosumab Biosimilar as required by patient's insurance.

☐ Administer this Denosumab product: _____ subject to prior authorization.

DOSING

☑ 60 mg subcutaneously in the upper arm, abdomen, or upper thigh

☑ Following initial Denosumab injection, observe patient for 15 minutes for hypersensitivity. Patients who have previously received and tolerated Denosumab do not require observation period.

FREQUENCY *(Choose one)*

☐ Repeat once in 6 months.

☐ Other: _____

LABORATORY ORDERS

☑ Order for serum calcium to be repeated 7-14 days before next 6-month dose provided to patient.

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Signs or symptoms of active infection or chance of pregnancy.
- Planned/recent invasive dental procedures.
- Jaw, thigh or groin pain, or dermatologic changes since starting Denosumab.
- A history of severe bone, muscle or joint pain following Denosumab injections.
- Lab levels showing hypocalcemia.
- Patient must be on Calcium and vitamin D orally unless contraindicated.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with biphosphates, Reclast, Prolia, Evenity. History of GERD, fractures, T score

Required Labs: Calcium and Vitamin D levels, Renal function

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.