

Denosumab (Bildyos, Conexxence, Jubbonti, Prolia, Stoboclo)

Provider Order Form rev. 7/6/2026

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.