Edward-Elmhurst Cancer Centers
120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/646-2273 Fax: 630/548-6617

24600 W. 127th Street; Plainfield, IL 60585
Phone: 630/646-2273 Fax: 630/548-6617

177 E. Brush Hill Road; Elmhurst, IL 60126
Phone: 630/646-2273 Fax: 331/221-3887

Prolia Injection Orders

Patient Name: _____ DOB: _____

*****Please include current history and physical and any recent labs/tests, if applicable*****

PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

Pre-Authorization # or Call Reference #: _____

(Ordering Physician Office is Responsible to Obtain Authorization/Referral)

☐ **Check if insurance requires drug to be provided by specialty pharmacy**

Contact Name and Phone Number of Insurance Company: _____

If you have any questions regarding pre-authorizations, please contact (630) 527-3788 and ask for the billing department.

Patient's Weight: _____

***PRIMARY DIAGNOSIS (ICD 10 REQUIRED)**: _____

SECONDARY DIAGNOSIS (ICD 10 REQUIRED): _____

***NOTE: If bone metastasis from solid tumor is reason for treatment, then bone metastasis must be primary diagnosis.**

Dosing: **Prolia 60mg** subcutaneous injection every six months x 2 doses

Pre-Injection Requirements:

This patient has a calculated creatinine clearance of greater than or equal to 30ml per minute and a normal serum calcium level **(labs must be done within 2 weeks of injection)** ☐ **Yes** ☐ **No**

Date of Lab Results (PLEASE ATTACH COPY): _____

Prolia Injection Orders

Pre-Injection Requirements:
Required lab work (Creatinine, Calcium, Phos,

Mg+) prior to Prolia may be done at Cancer Center on day of injection ☐ **Yes** ☐ **No**

Prolia Injection Orders

Pre-Injection Requirements:

Patient currently taking calcium and Vitamin D supplements ☐ **Yes** ☐ **No**

Patient can begin Prolia at the end of prior bisphosphonates dosing cycle ☐ **Yes** ☐ **No**

In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.

Physician Signature: _____ **Date:** _____

Ordering Physician NPI: _____ **Swedish Hospital NPI:** **1831151257**

_____ _____ _____

Physician Name (Please Print) **Office Phone** **Fax Number**

Revision/Review Date:12/2024