Northern Light Health

☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4589; Fax: 207-768-4183
☐ NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970
☐ NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801
☐ NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788
☐ NL Infusion Care, **Waterville**
Phone: 207-861-3380; Fax: 207-861-3348
☐ NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485
☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418
☐ NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917
☐ NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

OP denosumab (Prolia) (Paper)

Diagnosis: ☐ Senile Osteoporosis

☐ Other: _____ **ICD10:**_____

Height: _____ cm **Weight:** _____ kg

TREATMENT PARAMETERS:

Calcium level greater than or equal to 8 mg/dL

☑ Provider Communication *If Calcium Level is less than 8 mg/dL,* ***DO NOT ADMINISTER Denosumab (Prolia)*** *and* ***contact provider***

Laboratory:

☑ Calcium Level *BLOOD, Expedite, Pre-Procedure, Duration 12 Months, Prior to each denosumab (Prolia) injection*

Calcium Level: _____ Date: __/__/____ (Within 60 days of denosumab injection)

Medication:

☑ Denosumab (Prolia) *60 mg subcutaneously*

- ☐ *ONCE*
- ☐ *Every 6 months, 2 Doses/Times*

Other:

_____
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_____

Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

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PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS