Request for Prolia® (denosumab) At-Home Nurse Injection for Prolia® Patients

Fax (1-877-778-1287) or email (ProliaSupport@ubc.com) completed form to the UBC Prolia® Support Team

Nursing orders *(Physician signature required):*

Home Health Registered Nurse (HHRN) will perform Prolia® Injection Administration

Dosing Instructions: 60 mg every 6 months by subcutaneous injection

Amgen is arranging for at-home injection of Prolia® to address patient access needs resulting from the COVID-19 pandemic. This is a temporary service for patients identified to be part of a high risk group for COVID-19 or patients who do not have access to an alternative site of care. This service can be discontinued at any time. By signing this Request for Prolia® At-Home Nurse Injection Administration, you certify that you have:

(1) made the informed decision, based on your patient's clinical presentation, that (s)he is an appropriate candidate for Prolia®;

(2) prescribed Prolia® to your patient;

(3) determined that the requested at-home nurse injection services are medically necessary and appropriate;

(4) reviewed the information provided below and confirm it is accurate to the best of your knowledge;

(5) discussed with your patient receiving treatment in their home and the disclosure of their personal health information to Amgen and its agents necessary for completion of this service; and

(6) obtained appropriate patient authorization.

You also acknowledge and agree that this service is complimentary and provided at no cost to your patient, and agree that you will not charge any party, including patients, beneficiaries, and third-party payers, in connection with the service.

Physician Signature: X_____ Date: _____

Please complete all fields below:

Patient First Name:		Patient Last Name:	
Patient DOB (mm/dd/yyyy):		Preferred Language:	Gender: ☐ M ☐ F
Patient Address:		City: State: Zip:	
Patient Primary Phone #:		Patient Alternate Phone #:	
Patient Email (required for electronic consent):			
Is this patient transitioning from Evenity to Prolia?: ☐ Yes ☐ No		Is the patient: ☐ new to Prolia ☐ continuing Prolia	
Known Latex Allergies: ☐Yes ☐No	Pharmacy Name:	Pharmacy Phone:	
Last Injection Date:	Date Rx was Sent to Pharmacy for this Request:		
Prescriber First name:		Prescriber Last Name:	
Prescriber Address:		City: State: Zip:	
Preferred Method of Communication (circle one):		Email Fax	
Prescriber Email:		Prescriber Fax:	
State Medical License Number:			
Prescriber Phone:		Alternate Phone:	

Fax (1-877-778-1287) or email (ProliaSupport@ubc.com) completed form to the UBC Prolia® Support Team