



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION			
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ DEA: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____			
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)					
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____			
CLINICAL INFORMATION					
<input type="checkbox"/> M81.8 Osteoporosis, unspecified <input type="checkbox"/> M81.00 Osteoporosis without pathological fracture <input type="checkbox"/> Other (specify ICD-10): _____ T-Score (If known): _____ History of osteoporotic fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No Skeletal Site (If known): _____ Has the patient failed or is unable to tolerate bisphosphonate therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No ↳ If yes, please explain: _____ Does the patient have >1 risk factor for fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No ↳ If yes, please explain: _____ Reason for discontinuing previous osteoporosis therapies: _____ **Obtain the following labs at prior to start of treatment and at _____ frequency: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____					
TRIED AND/OR FAILED MEDICATIONS		LENGTH OF THERAPY			
_____/_____/_____		_____/_____/_____			
_____/_____/_____		_____/_____/_____			
EVENITY® ORDERS					
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection: _____					
Medication		Directions		Quantity/Refills	
<input type="checkbox"/> Evenity® (Romosozumab) 105mg/1.17 mL prefilled syringes (two-pack)		Inject 210 mg (two 105 mg syringes sequentially) subcutaneously into abdomen, thigh, or upper arm, once every month for 12 months.		<input type="checkbox"/> 1 Carton (2 Syringes) <input type="checkbox"/> Other: _____ Refills: _____	
Pre- Medication		Route		Dose	
<input type="checkbox"/> Acetaminophen		<input type="checkbox"/> By mouth		<input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg	
<input type="checkbox"/> Methylprednisolone (Solu-Medrol)		<input type="checkbox"/> IV		<input type="checkbox"/> 40mg <input type="checkbox"/> 100 mg <input type="checkbox"/> _____mg	
<input type="checkbox"/> Diphenhydramine (Benadryl)		<input type="checkbox"/> IV <input type="checkbox"/> By mouth		<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	
Other: _____		_____		_____	

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**ANAPHYLACTIC REACTION (AR):**

- ☐ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh  $\geq$  66 lbs ( $\geq$  30 kg); may repeat in 3-5 mins x 1 if necessary
- ☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg); may repeat in 3-5 mins x 1 if necessary
- ☐ Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary
- ☐ Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access
- ☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr
- ☐ Other: \_\_\_\_\_

**SIGNATURE**

We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral

X \_\_\_\_\_

Prescriber Signature

Date: \_\_\_\_\_

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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