EVENITY®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

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

☐ M81.8 Osteoporosis, unspecified ☐ M81.00 Osteoporosis without pathological fracture ☐ Other (specify ICD-10):_____

T-Score (If known): _____

History of osteoporotic fracture? ☐ Yes ☐ No Skeletal Site (If known): _____

Has the patient failed or is unable to tolerate bisphosphonate therapy? ☐Yes ☐ No

↳ If yes, please explain: _____

Does the patient have >1 risk factor for fracture? ☐ Yes ☐ No

↳ If yes, please explain: _____

Reason for discontinuing previous osteoporosis therapies: _____

**Obtain the following labs at prior to start of treatment and at _____ frequency: ☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ LFTs ☐ X-Ray ☐ Other: _____

TRIED AND/OR FAILED MEDICATIONS	LENGTH OF THERAPY	REASON FOR DISCONTINUATION

EVENITY® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection: _____

Medication	Directions	Quantity/Refills
☐ 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.	☐ 1 Carton (2 Syringes) ☐ Other: _____ Refills: _____

Pre- Medication	Route	Dose
☐ Acetaminophen	☐ By mouth	☐ 500mg ☐ 650mg ☐ 1000mg
☐ Methylprednisolone (Solu-Medrol)	☐ IV	☐ 40mg ☐ 100 mg ☐ _____mg
☐ Diphenhydramine (Benadryl)	☐ IV ☐ By mouth	☐ 25mg ☐ 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 ≥ 66 lbs (≥ 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_____ Date: _____

Prescriber Signature

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.