# Evenity
(romosozumab)

Advanced Infusion Care Centers

## PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

## PRIMARY DIAGNOSIS

☐ M80.00xA Age-related osteoporosis with current pathological fracture, initial encounter

☐ M80.00xS Age-related osteoporosis with current pathological fracture, sequela

☐ M81.0 Age-related osteoporosis without current pathological fracture

☐ Other: _____

## PRESCRIPTION

☐ Evenity 210mg subQ once monthly for 12 doses

☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

☑ Refill x 12 months unless otherwise noted: _____

## REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- Most recent labs (including current Calcium level)
- DEXA Scan

## ANCILLARY ORDERS

### ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*
- Epinephrine (weight-based dosing) PRN per protocol

☐ Other: Please fax other reaction orders if checking this box

### PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended standard pre-meds for Evenity.

☐ Provider Prescribed: _____

### LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

## PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*