



EVENITY™ (Romosozumab-aqqg) ORDER FORM **STAT REQUEST**
(- Required Fields)* >(*REASON MUST BE PROVIDED BELOW)

New Referral **Order Renewal** **Medication/Order Change**
 Benefits Verification Only **Discontinuation Order**

PATIENT INFORMATION

NAME*:	DOB*:	SEX: M F	
ADDRESS:	PHONE:		
WEIGHT: LBS KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION

PHYSICIAN NAME*:	PRACTICE NAME:
ADDRESS:	OFFICE CONTACT*:
PHONE: FAX:	EMAIL (FOR UPDATES):

EVENITY ORDER*: _____ **ICD-10*:** _____
(SELECT ONE OF THE FOLLOWING)

Dosing: 210 mg subcutaneously once every month for 12 doses

Patient is taking a minimum of Calcium 1000mg and Vitamin D 400IU daily: Yes No

Physician Signature* _____ Date*(Order is Valid for One Year) _____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

Osteoporosis
 Osteoporosis Postmenopausal
 Other _____

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocols)

Last Infusion/Injection Date: _____

REQUIRED DOCUMENTATION CHECKLIST:

Patient Demographics
 Insurance Card/Information
 Clinical/Progress Notes supporting DX
 Current Medication List and H&P
 DEXA Results **if no -2.5 T score, please send history of fracture documentation*
 Normal Calcium Level within 90 days of first injection
 Patient has not had a myocardial infarction or stroke within the preceding year

NOTES/ADDITIONAL COMMENTS:

Locations:

-----**Colorado**-----

Lakewood

-----**Florida**-----

- Jacksonville
- Kissimmee
- Port St. Lucie
- Suncoast
- Winter Park

-----**Texas**-----

- Arlington
- Cedar Hill
- Dallas
- Denton
- Ft. Worth
- Irving
- Rockwall
- Southlake
- Flower Mound
- Plano
- Tyler