

EVENITY (romosozumab-aqqg)

New Prescription/Referral
Prescription Refill

Of Refills:

Rx:

Patient Name:

Patient Weight:

kg

DOB:

Eventy:
(romosozumab-aqqg)

210 mg SubQ once a month for 12 doses

Others: _____

Pre-Medication:

ANA Kit Protocol:

Solumedrol 125mg IVP

Tylenol _____ mg PO

Benadryl _____ mg PO

OK to use

Solu-Cortef 100mg IVP

650 mg 975 mg

25 mg IV

Others: _____

50 mg PO

Dx: **Diagnosis:** Age-related osteoporosis without current pathological fracture (ICD-10: M81.0)
Age-related osteoporosis with current pathological fracture, initial encounter (ICD-10: M80.00XA)
Age-related osteoporosis with current pathological fracture, unspecified site, sequela (ICD-10: M80.00XA)
Other: _____
ICD-10: _____

Physician Signature

NPI #:

DATE:(Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

Clinic:

Phone:

Fax:

Email:

Other:

Office Mailing Address:

Please include the following.

Patient demographics

Insurance attached

Diagnosis(supporting)

History & Physical

Lab Results

Clinical progress notes

Medication list

Other Test Results

Dexa Results (if no -2.5 T score, please send history of fracture documentation)

Normal Calcium Level within 1 year of first injection

No hx of MI or stroke in preceding year

CrCl clearance

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.