

# Evenity (romosozumab-aqqg)

Provider Order Form rev. 1/5/2025



## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Gender:  M  F  Other

Email Address: \_\_\_\_\_ Address: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height (in): \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_ Existing prior authorization?  Yes, (Send a copy)  No (AIC will process)

Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## Patient Preferred Location:

## DIAGNOSIS & CLINICAL INFORMATION

### ICD 10-Code & Description (Provide full completed code)

M81.0 Age-related osteoporosis without current pathological fracture  
 M81.8 (other osteoporosis without current pathological fracture)  
 M80.00 Age related osteoporosis with current pathological fracture,

unspecified site  
 Z87.310 Personal history of healed osteoporosis fracture  
 Other: \_\_\_\_\_

**REQUIRED DOCUMENTATION:** Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results ( CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

## PRESCRIPTION INFORMATION

**Nursing:** Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

### Pre-Medications

Acetaminophen (Tylenol)  500mg  650mg  1000mgPO  
 Cetirizine (Zyrtec) 10mgPO  
 Loratadine (Claritin) 10mgPO  
 Diphenhydramine (Benadryl)  25mg  50mg  PO  IV  
 Methylprednisolone (Solu-Medrol)  40mg  125mg IV  
 Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

### Lab Orders

*Required:*  
Dexa Scan Date: \_\_\_\_\_ T-Score: \_\_\_\_\_ Current  
Calcium Levels : Serum Ca: \_\_\_\_\_  
CMP/BMP  
 Other: \_\_\_\_\_

### Evenity (romosozumab-aqqg) SC (Select one):

Inject 210 mg subcutaneously once a month for 12 doses. Refill x 1 year.

A full dose of EVENITY requires two single-use prefilled syringes

**Post Treatment Observations:** The patient is required to stay for 30 minutes following the first administration.

### Special Instructions:

Refills:  zero  6 months  12 months  \_\_\_\_\_ (*Prescription valid for one year, unless otherwise indicated*)

## PROVIDER INFORMATION

Provider Full Name: \_\_\_\_\_ Provider NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Provider Name (Print)

Provider Signature

Date