Evenity

romosozumab-aqqg

INFUSE ONE OHIO

Treatment Location: ☐ Dublin, OH ☐ Lancaster, OH

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, BMP (including serum calcium, creatinine, and eGFR), DEXA scan

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ _____ ☐ M81.0 ICD Description:

Allergies: Weight (lbs/kg): Height:

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

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

☑ Center will use Hypersensitivity protocol established by Infuse One Ohio

☑ T Score, DEXA (list results, include original images & reports):

_____

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

THERAPY ADMINISTRATION

☑ Evenity SQ Injection
Dose: 210mg (2 x 105mg)
Frequency: Every month for 12 monthly doses
Route: Subcutaneous Injection

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS:

Provider Name (Print) | Provider Signature | Date

☐ ***Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***