

EVENTITY® (romosozumab-aqqg)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
DOB: _____ Allergies: NKDA _____
Phone Number: _____
Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List Serum calcium level within one year of injection
 Clinical/Progress Notes Supporting Dx DEXA scan and/or FRAX score
 Negative history of myocardial infarction and stroke within the proceeding year

Primary Diagnosis

 ICD-10 Code (required): _____

- Osteoporosis Other: _____

Therapy Administration

- Evenity subQ 210mg every month
 Other: _____

Refills:

- x 1 year Other: _____

 Order valid for one year unless otherwise stated

- Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)
 RN to administer ordered therapy per manufacturer guidelines.
 Other: Please fax alternative reaction orders or nursing administration orders if checking this box

Special Orders

Provider Information

Provider Name: _____ Office Contact Person: _____
Referring Practice Name: _____ Phone Number: _____
Referring Practice Address: _____ Fax Number: _____
City, State, Zip: _____ Email: _____
Provider NPI: _____
Provider Signature: _____ Date: _____