

# 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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Patient Demographics and Insurance Card   | <input type="checkbox"/> Medication List             | <input type="checkbox"/> Serum calcium and creatinine |
| <input type="checkbox"/> Clinical/Progress Notes Supporting Dx   | <input type="checkbox"/> DEXA scan and/or FRAX score | <input type="checkbox"/> Recent oral examination      |
| <input type="checkbox"/> 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](http://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: \_\_\_\_\_