

# EVENITY

Please include the following to expedite the order:  
Patient Demographics, Insurance Information, Labs

## PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: ☐ M ☐ F ☐ Other \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

## PRESCRIBER

Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_ State License: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## CLINICAL

Diagnosis: ☐ M80.0\_\_ (Age-related Osteoporosis w/ current pathological fracture)  
☐ M81.0 (Age-related Osteoporosis w/o current pathological fracture) ☐ Other: \_\_\_\_\_  
Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ ☐ kg ☐ lbs Height: \_\_\_\_\_ ☐ cm ☐ in  
CBC Completed: ☐ Yes ☐ No CMP/LFTs Completed: ☐ Yes ☐ No T-Score: \_\_\_\_ DEXA Date: \_\_\_\_\_

## TREATMENT

**EVENITY (romosozumab-aqqg)**

**Route:** Subcutaneous injection

**Dose:** ☐ 210 mg (2x105mg)

**Frequency:**

☐ Every month for 12 monthly doses

**Premedication Protocol:** (Not Usually Indicated)

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV  
☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO  
☐ Other: \_\_\_\_\_

Sig: \_\_\_\_\_

☒ Center will use anaphylactic and hypersensitivity protocol established by Restore Health

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Quantity:** \_\_\_\_\_ **Refills:** \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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