RESTORE HEALTH
INFUSION AND WELLNESS

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: _____