

MRN: _____

Phone: **1-800-809-1265** Fax: **1-866-872-8920**

DOB: _____

STANDARD Evenity™ (romosozumab-aqqg) PLAN OF TREATMENT

NOTE: Patient may be ineligible to receive Evenity™ with hypocalcemia. Pre-existing hypocalcemia must be corrected prior to initiating therapy.

1. Patient Name: _____ Height (inches): _____ Weight (lbs): _____

2. Allergies: _____

3. Diagnosis: * Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing

M80.0___ Age-related Osteoporosis with current pathological fracture

M81.0 Age-related Osteoporosis without current fractures

Other **ICD-10 Code:** _____ **Diagnosis description:** _____

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4. History: Is the patient on Calcium and Vitamin D replacement? Yes No

(It is recommended that patients should be adequately supplemented with Calcium and Vitamin D while on Evenity.)

5. Orders:

Evenity™ 210mg Total Dose monthly for 12 months.

(Administer as two separate 105 mg subcutaneous injections only to upper arm, upper thigh, or abdomen)

Clinical Lab Monitoring: *Monitor serum Calcium level and hold dosing if serum Calcium sub-therapeutic.*

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

6. Physician's Signature: _____ / _____ Date: _____
No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____ NPI: _____

7. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

