

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

## Evenity™ (romosozumab-aqgg) Standard Plan of Treatment

### PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
<input type="checkbox"/> See list	<input type="checkbox"/> NDKA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

M80.0 - Age-related Osteoporosis with current pathological fracture
M81.0 - Age-related Osteoporosis without current fractures
- Other:

### REQUESTED DOCUMENTATION:

### PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INJECTION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INJECTION DATE:
4	Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b>
5	Serum Calcium level required	THERAPY:	<b>Continue current order until insurance approved</b>
6	DEXA Scan results showing Osteoporosis		

### MEDICATION ORDERS:

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

### DOSE/FREQUENCY:

Evenity™ 210mg Total Dose given subcutaneously monthly

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

### LAB PARAMETERS: (Pharmacist to perform clinical lab monitoring)

Serum Calcium is below normal range: dose will be held unless written clearance is provided by MD

### SPECIAL ORDERS:

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Refills x 12 total doses unless noted otherwise here:

### LINE USE/CARE ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure

### ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRx standing adverse reaction orders, which can be found at our website or scan here.



### PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

### PRESCRIBER SIGNATURE: (No stamp signatures)

DATE

Dispense as written/Brand medically necessary	Substitution permitted



## Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- Patient demographics – address, phone number, SS#, etc.**
- Insurance Information – copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

[www.AccuRXInfusion.com](http://www.AccuRXInfusion.com)