Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Evenity® (romosozumab-aqqg) 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:	☐ See list	☐ NDKA	

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD 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:

REQUIRED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES: Number of injections administered:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Serum Calcium level required		☐ **Continue current order until insurance approved**
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. ONJ has been reported in patients on romosozumab-aqqg. A routine oral exam is recommended to be performed by the prescriber prior to start of romosozumab-aqqg treatment.

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)

☐ Prescriber clearance waived for recent or planned dental procedures.

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:

☐ _____

☑ Refills x 12 total doses unless noted otherwise here:

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	

Palmetto
INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- ☐ **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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com

02/10/2023