

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

Rev 3.4.25

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:
	See list
	NKDA

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:
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	IF ORDER CHANGE:
5 Serum Calcium level required	THERAPY:	
6 DEXA Scan results showing Osteoporosis		
		Continue current order until insurance approved

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-aqgg. A routine oral exam is recommended to be performed by the prescriber prior to start of romosozumab-aqgg 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)

CONTINUATION OF THERAPY:

Continuation of therapy: Patient has received ___ doses with previous provider; Palmetto Infusion Services to provider the remainder of subsequent doses as noted above.

LAB PARAMETERS:

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

SPECIAL ORDERS:

Prescriber clearance waived for recent or planned dental procedures.

Refills x 12 total doses unless noted otherwise here:

NURSING ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.
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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 Palmetto Infusion: Fax referral to 1.800.521.9640

- 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com