EVENITY
(romosozumab)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- DEXA Scan
- Current Calcium Level (within 6 months)
- CrCl clearance

PRIMARY DIAGNOSIS

*Medicare currently only reimburses for female claims

☐ M80.00xA Age-related osteoporosis with current pathological fracture, initial encounter
☐ M80.00xS Age-related osteoporosis with current pathological fracture, sequela
☐ M81.0 Age-related osteoporosis without current pathological fracture
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

_____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Evenity
☐ Provider Prescribed: _____

_____

PRIMARY MEDICATION ORDER

☑ Evenity 210mg (two 105mg subQ injections) once monthly for 12 doses
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____

Provider Signature Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals

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