BioTek reMEDys®

EVENITY®

Please Fax Completed Form To: **800-783-9146**

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
City, State, Zip: _____
Plan #: _____
Group #: _____
Phone: _____

RX Card (PBM): _____
BIN: _____ PCN: _____
City, State, Zip: _____
Group #: _____
Phone: _____

CLINICAL INFORMATION

☐ICD-10 Code: _____	☐Diagnosis Description: _____
☐M81.0 (Age-related osteoporosis without current pathological fracture)	Latex Allergy ☐ Yes ☐ No
☐M80.0 (Age-related osteoporosis with current pathological fracture)	Drug Allergies: _____
Tests completed: ☐ T-score ☐ Dexa Scan ☐ Calcium (Please provide results)	Initial Infusion ☐ Yes ☐ No (If no, date of last infusion) _____
Patient currently taking vitamin D and calcium supplements ☐ Yes ☐ No	Calcium level available ☐ Yes ☐ No

TRIED AND/OR FAILED MEDICATIONS	LENGTH OF THERAPY	REASON FOR DISCONTINUATION
_____/	_____/	_____
_____/	_____/	_____

(DRUG NAME) ORDERS – this section may not be needed)

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Infusion/Injection: _____

Medication	Directions	Quantity/Refills
☐ Evenity (Romosozumab) 105 mg/1.17 ml PFS	Inject 210mg (2 syringes) SQ once every month for 12 total doses	

☐ Other:

☐ Has patient already received doses of Evenity? Total doses delivered: _____ Date of last injection: _____

Pre-medication: _____

SIGNATURE

X_____ Date: _____

Prescriber Signature