

PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		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			
<input type="checkbox"/> ICD-10 Code: _____		<input type="checkbox"/> Diagnosis Description: _____	
<input type="checkbox"/> M81.0 (Age-related osteoporosis without current pathological fracture)		Latex Allergy <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M80.0 (Age-related osteoporosis with current pathological fracture)		Drug Allergies: _____	
Tests completed: <input type="checkbox"/> T-score <input type="checkbox"/> DEXA Scan <input type="checkbox"/> Calcium (Please provide results)		Initial Infusion <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, date of last infusion) _____	
Patient currently taking vitamin D and calcium supplements <input type="checkbox"/> Yes <input type="checkbox"/> No		Calcium level available <input type="checkbox"/> Yes <input type="checkbox"/> No	
TRIED AND/OR FAILED MEDICATIONS	LENGTH OF THERAPY	REASON FOR DISCONTINUATION	
_____ / _____	_____ / _____	_____ / _____	
_____ / _____	_____ / _____	_____ / _____	
(DRUG NAME) ORDERS – this section may not be needed			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Infusion/Injection: _____			
Medication	Directions	Quantity/Refills	
<input type="checkbox"/> Evenity (Romosozumab) 105 mg/1.17 ml PFS	Inject 210mg (2 syringes) SQ once every month for 12 total doses		
<input type="checkbox"/> Other: _____			
<input type="checkbox"/> Has patient already received doses of Evenity? Total doses delivered: _____ Date of last injection: _____			
Pre-medication: _____			
SIGNATURE			
X _____		Date: _____	
Prescriber Signature			

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