

Evenity (romosozumab-aqqg) Injection Orders

Patient Name: _____ DOB: _____ Male Female

Diagnosis (please provide ICD10 code) Age-related osteoporosis without current pathological fracture M81.0

Age-rel osteopor w current path fracture, unsp site, init. M80.00XA NKDA Allergies: _____

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider:

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

TRIED AND FAILED MEDICATIONS:

- Fosamax Boniva Actonel Evista Reclast

Contraindications to above: _____

*NOTE: As of January 2023 most major Insurance plans require trial/failure of both oral and IV bisphosphonate therapy (such as Reclast and Prolia) before approving Evenity treatment. If your patient has not tried and failed or has a contraindication to oral or IV bisphosphonate and you still would like to pursue Evenity treatment, we encourage an addendum, progress note or letter of medical necessity explaining why step therapy is not recommended/beneficial for the patient i.e contraindication, intolerance, allergy, etc.

EVENITY ORDERS

DOSING:

- Evenity 210mg (two 105mg prefilled syringes) subcutaneous injections

FREQUENCY:

Once a month for 12 doses

Infuse One Standing Orders:

Provide treatment under Infuse One's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name

Provider Signature

REQUIRED TESTING/LABS:

- Clinical/Progress Notes supporting primary diagnosis (please attach)
- DEXA scan results and date (please attach): _____
- Calcium level and date (please attach most recent CMP): _____

REFILLS:

- _____

(if not indicated prescription will expire one year

from date signed)

Date