Evenity® (romosozumab-aqqg) Referral Form

Patient Preferred Clinic (select one): _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per VIVO protocols.

LABORATORY ORDERS

☐ CBC ☐ at each dose every _____
☐ CMP ☐ at each dose every _____
☐ CRP ☐ at each dose every _____
☐ OTHER

Other Notes:

EVENITY THERAPY ADMINISTRATION

☐ 210mg subcutaneously once a month for 12 doses

REQUIRED DOCUMENTATION

☐ **Patient Demographics**
☐ **Insurance Card/Information**
☐ **Progress Notes Supporting DX**
☐ **Current Medication List and H&P**
☐ **Dexa Results** (if no -2.5 T score, please send history of fracture documentation)
☐ **Normal Calcium Level within 1 year of first injection**
☐ **No hx of MI or stroke in preceding year**

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Provider Name (Print) **Provider Signature** **Date**

Fax Numbers

☐ Colorado: 303-418-4679
☐ Florida: 904-930-4211
☐ Texas: 469-340-0044
☐ Nevada: 702-489-5744
☐ New Jersey: 609-955-3711
☐ Ohio: 216-400-0674
☐ Oklahoma: 918-770-4421
☐ Massachusetts: 203-724-4838
☐ Pennsylvania: 215-399-9244
☐ New York: 203-724-4838
☐ Connecticut: 203-724-4838

Have a Question? (720) 902-4111

Email Referrals To: referrals@vivoinfusion.com

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