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 90 days 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**

Have a Question? (212) 776-9090
Email Referrals To: info@specialtyinfusion.com
Fax Referrals To: (800) 540-1852
E-Prescribe: QuickRx 2nd Ave, 2355 2nd Avenue, New York NY 10035 Tel: 212-858-0659

Revision Date 8/2023