PRESCRIPTION ORDER FORM

EVENITY
(romosozumab)

Suite Life
Infusing health and wellness into your life.

Central Fax: 800-504-0870

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- DEXA Scane
- History & Physical
- Current Calcium Levels (within 6 months)
- Patient Demographics
- Most Recent Labs
- Medication List

PRIMARY DIAGNOSIS

☐ M80.00xA Age-related osteoporosis with current pathological fracture, initial encounter

☐ M80.00xS Age-related osteoporosis with current pathological fracture, sequela

☐ M81.0 Age-related osteoporosis without current fracture

☐ Z 87.310 Personal history of healed osteoporosis fracture

☐ Other: _____

CLINICAL MONITORING: Recommended lab to be maintained and monitored by prescriber

☑ Calcium q6 months

PRE-MEDICATIONS: **No standard premedications typically indicated**

☐ Diphenhydramine 25mg PO or IVP & 50mg PO or IVP ☐ Cetrizine 10mg PO ☐ Pepcid 20mg PO or IVP

☐ Solu-Medrol 40mg IVP ☐ Solu-Medrol 125mg ☐ Tylenol 650mg PO ☐ Other: _____

PRIMARY MEDICATION ORDER: ** If necessary, Suite Life will round dose up/down according to payor guidelines**

☐ Evenity 210mg (two 105mg SubQ injections) once monthly for 12 doses

☐ Other:_____

Please ensure pt has no history of stroke or MI in the last year.

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____

Provider Signature Date

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