

## EVENTY ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO  
REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Patient's Name (Last, First, Middle) \_\_\_\_\_ DOB \_\_\_\_\_

Patient's height in feet and inches \_\_\_\_\_ Patient's weight in pounds \_\_\_\_\_

### ■ Diagnosis

M80.o \_\_\_\_\_ Age-related osteoporosis w/ fx at \_\_\_\_\_

M81.8 Other osteoporosis w/o fx

M81.o Age-related osteoporosis w/o fx

\_\_\_\_\_

**Note:** M80.o \_\_\_\_\_ requires the complete ICD-10 code, with 3 digits and a letter after the decimal. Some insurance carriers may not accept all such codes.

### ■ Details Needed for Approval *Please answer all questions and provide supporting documentation.*

- If female, does the patient have a BMD T-score  $\leq -2.5$ ? \_\_\_\_\_ Osteopenia with T-score between -1 and -2.5? \_\_\_\_\_
- Has the patient had a low-trauma spine or hip fracture? \_\_\_\_\_
- Has patient failed a trial on, or is intolerant to, bisphosphonate and/or other osteoporosis therapy? \_\_\_\_\_
- Is the patient considered at high risk of fracture? \_\_\_\_\_ Please provide all supporting documentation.
- Please provide the patient's most recent calcium levels. (Most insurers want results from the past 4 weeks.)
- Is patient planning to concomitantly take parathyroid hormone analogs, RANK ligand inhibitors, or bisphosphonates?  
\_\_\_\_\_
- Will the patient be taking a daily supplement of at least 1000mg calcium and at least 400 IU vitamin D? \_\_\_\_\_

### ■ Premedication Order

Oral medications to be taken by the patient at least 60 minutes prior to start of infusion treatment. May be taken at home:

Acetaminophen \_\_\_\_\_ mg

Diphenhydramine \_\_\_\_\_ mg

Cetirizine 10mg

IV medications to be administered prior to start of the infusion treatment (for infusions only, not for injections):

Diphenhydramine \_\_\_\_\_ mg

Methylprednisolone \_\_\_\_\_ mg

\_\_\_\_\_

### ■ Medication Order

Evenity (romosozumab-aqqg) 210mg SubQ injection. Administer every month for 1 year.

### ■ Rescue Management in Case of Reaction

*These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.*

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

### ■ Ordering Provider Authorization

Provider Signature: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Indiv. NPI #: \_\_\_\_\_ License: \_\_\_\_\_

Best Contact Person in Office: \_\_\_\_\_ Direct Phone to Contact Person: \_\_\_\_\_

### Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.