Evenity (Romosozumab-aqqg) Treatment Plan

Patient Sticker Here

Patient Name: _____ Height (cm): _____ Weight: _____

Allergies:_____

Diagnosis (choose option below):

☐ M80.0___ Age-related osteoporosis <u>with</u> current pathological fracture

☐ M81.0 Age-related osteoporosis <u>without</u> current pathological fracture

☐ Other ICD-10 code: _____ Diagnosis Description: _____

Patient Medical Information:

****Please include H&P and most recent notes with Treatment Plan****

Does patient have a history of myocardial infarction (MI) or stroke within the past year? ☐ Yes ☐ No

<u>Evenity should NOT be initiated in patients with a history of MI or stroke within the past year!</u>

Patient currently on Calcium and Vitamin D replacement? ☐ Yes ☐ No

Last Serum Calcium (mg/dL): _____ Date of Last Serum Calcium: _____

Original Diagnostic T-Score: _____ T-Score Date: _____

Last Oral Exam: ____/_____/_____ **If available attach dental records with this document**

If no dental records are available, please schedule checkup prior to initiation of therapy and consider repeating examination in 3 – 6 months

Prior Osteoporosis Treatment(s) (select <u>all</u> previous treatments):

☐ Alendronate (generic) ☐ Fosamax (alendronate sodium)

☐ Actonel (risedronate sodium) ☐ Boniva (ibandronate sodium)

Other: _____

Lab & Miscellaneous Orders:

Fax lab results to physician after each visit: ☐ Yes ☐ No

☐ Serum Calcium Level ☐ Serum Vitamin D Level ☐ Dexa Scan ☐ Routine Oral Exam

Additional lab orders prior to treatment: _____

Medication Orders:

☐ Evenity 210 mg once monthly x 6 months (may reorder once for a total of twelve months)

Last Evenity dose: ____/_____/_____ Evenity dose number: _____

Administer only to upper arm, upper thigh, or abdomen

Max therapy duration is 12 months

Parameters

☐ Hold dose if serum calcium level is subtherapeutic (<8.8 mg/dL)

☐ Other Parameters: _____

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____

Insurance/Authorization Information:

Product Information for Authorization: Romosozumab-aqqg (Evenity) (J3590)

If a different product is requested list name and HCPCS code: _____

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Florence: 843-777-6001 (Fax)

843-777-4655 (Phone)