

Evenity (Romosozumab-aqqg) Treatment Plan

Patient Sticker Here

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

Allergies: _____

Diagnosis (choose option below):

M80.0 Age-related osteoporosis with current pathological fracture

M81.0 Age-related osteoporosis without 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

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

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 all previous treatments):

Alendronate (generic)

Fosamax (alendronate sodium)

Other: _____

Actonel (risedronate sodium)

Boniva (ibandronate sodium)

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.

Seacoast: 843-366-2224 (Fax)

843-366-3626 (Phone)