Romosozumab-aqqg (Evenity)

Provider Order Form rev. 7/29/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

☐ M80. ____: Osteoporosis w/ pathological fx ☐ M81. ____: Osteoporosis w/o pathological fx

☐ Other: Description:

REQUIRED INFORMATION

☑ patient has NOT had an MI or stroke in the past year
☑ Recent calcium level: _____ mg/dl
Date of result: _____ (please include copy)
☐ Ok to use this lab result for Evenity injection.

THERAPY ADMINISTRATION

☑ Administer Evenity 210mg subcutaneously in the upper arm, abdomen, or upper thigh. Provided as 2 separate 105mg/1.17ml prefilled syringes. Rotate site with each injection.
☑ Following initial Evenity injection, observe patient for 15 minutes for hypersensitivity. Patients who have previously received and tolerated Evenity do not require observation period.

FREQUENCY *(Choose one)*

☐ Repeat once a month for 12 months
☐ Other: _____

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Other: _____

LABORATORY ORDERS

☐ CBC w/ diff ☐ at each dose ☐ every: _____
☐ CMP ☐ at each dose ☐ every: _____
☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Hold for hypocalcemia at initiation of treatment.
- Ensure patient is taking daily calcium and vitamin D supplement.
- Planned/recent invasive dental procedures.
- Jaw, thigh or groin pain, or dermatologic changes since starting Evenity.
- A history of severe bone, muscle or joint pain following Evenity injections.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with biphosphates, Reclast, Prolia, Evenity. History of GERD, fractures, T score
Required Labs: Calcium , Renal function

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.