

Evenity Injection



InfusionForHealth.com

Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order.

Demographics, Insurance Information, Current Medications, Original DEXA Images and Reports, Office Notes, Current CBC & CMP

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: M80.0 Age-related Osteoporosis with current pathological fracture
 M81.0 Age-related Osteoporosis without current fractures

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Center will use Hypersensitivity protocol established by Infusion for Health and P.I.

EVENITY DOSAGE

Date of Last Treatment, If Continuation: _____

**210 mg subcutaneous (2 x 105 mg)
once a month for 12 months**

***See package insert regarding serum calcium monitoring.**

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

Lab Orders: List: _____

Prior to first appointment Other Frequency: _____

Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.