



# Eventy Order Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

### DIAGNOSIS:

- Age-related osteoporosis without current pathological fracture (ICD-10:M81.0)
- Other osteoporosis without current pathological fracture (ICD-10 Code: M81.8)
- Age-Related Osteoporosis with current pathological fracture (ICD-10 code: M80.0 \_\_\_\_\_)\*\* Complete code\*\*
- Other \_\_\_\_\_ ICD-10: \_\_\_\_\_

### ORDER FOR EVENTY (ROMOSUZUMAB-APPG):

- 210 mg (105mg in two separate injections) SC injection once every month x 1 year**
- Other Dose:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_ x 1 year

### MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- Nevada Infusion Hypersensitivity Reaction Order Set**
- Other: \_\_\_\_\_

NURSING: Per Nevada Infusion

### LABS ORDERS: CMP prior to initiation of drug therapy

Additional Lab Orders: \_\_\_\_\_

Fax results to: \_\_\_\_\_

### PROVIDER INFORMATION:

Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Point of Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478**

\*\*Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. \*\*



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Please Include Required Documentation for Expedited Order Processing & Insurance Approval:**

- Signed Provider orders (page 1)
- Patient demographic and insurance information
- Patient's current medication list
- Supporting recent clinical notes and H&P (to support primary diagnosis)
  - Original Diagnostic T-Score: \_\_\_\_\_ T-Score Date: \_\_\_\_\_
  - History of osteoporotic fracture
  - Prior Osteoporosis Therapy (if any):
    - Generic alendronate
    - Fosamax® (alendronate sodium)
    - Actonel® (risedronate sodium)
    - Boniva® (ibandronate sodium)
    - Other \_\_\_\_\_
  - Reason for Discontinuing Previous Osteoporosis Therapy(ies): \_\_\_\_\_
  - Contraindications (if any): \_\_\_\_\_
  - Patient is currently taking calcium and vitamin D supplements:
    - Yes OR  No
  - Calcium level available:
    - Yes OR  No

Any Additional Pertinent Information: \_\_\_\_\_

**Additional REQUIRED Information:**

- Include labs and/or test results to support diagnosis
- Calcium levels (within 6 months) - please attach results
- DEXA Scan - please attach results**
- Other medical necessity: \_\_\_\_\_

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