

EVENITY
(romosozumab-aqqg)
SUB Q

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Dexa Scan (-2.5 T score or more severe)
***if no -2.5 T score, please send history of fracture documentation*
- Documentation to support primary diagnosis
(Clinical/progress notes, other medications tried & failed, labs, diagnostic tests, etc.)
- Required Labs: Calcium within 30 days prior to initial dose**

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis ICD-10: Senile Osteoporosis (ICD-10: ____)
Other _____ (ICD-10: ____)

J Code: J3590

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Patient Wt. _____ kg

*Patient is currently taking calcium/vitamin D supplementation YES NO

Date of last Prolia injection _____

Evenity (romosozumab- aqqg) 210mg Subcutaneously once per month for 12 doses.

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	