Evenity® (Romosozumab)

Referring Physician Order Form Rev. 4/2025

Please fax completed referral form & all required documents to 208-595-4427

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Osteoporosis with current fracture (M80.0 – M80.8), ICD10 _____ ☐ Other: _____, ICD10 _____

☐ Osteoporosis without current fracture (M81.0)

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Evenity® (romosozumab)	210 mg	Inject SUBQ every 1 month x 1 year

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ Blood glucose q _____ ☐ CBC with diff/platelet q _____

☐ CMP q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

☐ Yes ☐ No Is the patient at high risk for fractures?

If yes, please select all that apply:

☐ History of fragility (non-traumatic) fracture

☐ Multiple risk factors for fracture:

- ☐ anorexia nervosa
- ☐ alcohol intake (4 or more units/day)
- ☐ corticosteroid therapy
- ☐ smoking
- ☐ Other: _____
- ☐ elderly
- ☐ low body mass
- ☐ parental history of hip fracture
- ☐ rheumatoid arthritis

LAB AND TEST RESULTS (required)

☐ Bone Mineral Density (BMD) test ☐ Other: _____

PRIOR FAILED THERAPIES FOR OSTEOPOROSIS (including oral/IV bisphosphonates, SERM)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

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