INTRAMED Plus
infusion services

EVENITY®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____Age-related Osteoporosis with current fracture ICD-10 Code: M80.0._____
_____Age-related Osteoporosis without current fracture ICD-10 Code: M81.0._____
_____Other: ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
  Any recent history of heart attack or stroke in the past year
- Documentation of therapies previously trialed and failed
- Dexa Scan Results indicating osteoporosis
- Recent serum calcium
- Recent dental exam results
- Current medication list:
  - Patient is currently receiving calcium/vitamin D supplementation:
    ❑ Yes ❑ No ❑ Other:_____
  - Was the patient previously receiving a bisphosphonate: ❑ Yes ❑ No
    If yes, therapy was discontinued: _____
    If yes, desired wash-out period prior to starting Evenity: _____weeks

Patient Weight: _____ lbs.
Height: _____ in.

EVENITY® (romosozumab-aqqg) J Code: J3111

4. Drug Order:

Evenity 210 mg once monthly _____ # Refills (ecommend 11)

Administer 210 mg subcutaneously each month

- Each dose will require two syringes (105 mg/1.17 mL each)

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**