175MemorialHighway.Suite1-1
NewRochelle,NY
1080

914-460-489
fuse@fuseinfusion.com
914-460-4571

☐ __________ ok the switch to biosimilar if insurance formulary prefers

MEDICATION ORDERS EVENITY ROMOSOZUMAB (aqqg)

Date: ____________________

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
☐New Referral	☐Dose or Frequency Change	☐Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Age related Osteoporosis without current pathological fracture	ICD10 Code: M81.0
☐ Age related Osteoporosis with current pathological fracture	ICD10 Code: M8 0.0
☐ Other Diagnosis: ______________________________________	ICD10 Code: ____________________

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Serum calcium level	☐ DEXA scan results and/or FRAX score
☐ Documentation of oral hygiene	
List Tried & Failed Therapies, including duration of treatment (please comment specifically on bisphosphonates) :	
1)	
2)	

MEDICATION ORDERS			
Dosing	☐ Evenity 210mg SubQ once monthly (given as two injections of 105mg each)		
Refills:	☐ X 6 months	☐ X 1 year	☐ _____ doses

PRESCIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

ORDERING PROVIDER

Signature **X** ______________________________________ Date ______________

Provider ______________________________ Phone ____________ Fax ______________