

Community Health Interventions Specialty Clinic MEDICATION ORDERS-EVENTINY (ROMOSOZUMAB)

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

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Age related Osteoporosis without current pathological fracture	ICD10 Code: M81.0
<input type="checkbox"/> Age related Osteoporosis with current pathological fracture	ICD10 Code: M80.0
<input type="checkbox"/> Other Diagnosis: _____	ICD10 Code: _____

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

MEDICATION ORDERS	
Dosing	<input type="checkbox"/> Eventiny 210mg SubQ once monthly (given as two injections of 105mg each)
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

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

Contact us with questions at: jeff@eastoninfusion.com or call 728-777-5546

Fax completed form and all documentation to (561) 709-8626

All information contained in this form is strictly confidential and will become part of the patient's medical record.