EVENITY (romosozumab-aqqg) Referral Order Form

WWW.PACEINFUSION.COM
PH:330-625-4900
F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Rqd.)* ☐ Verify Benefits Only ☐ D/C Infusions **indicate name of drug(s)*

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____

Phone # _____

Email: _____

Insurance ID #: _____

PRESCRIBER INFORMATION

Referring Physician: _____

Address: _____

_____

Office Contact: _____

Phone # & Ext.: _____ _____ Fax #: _____

Direct Message Address _____

EVENITY MEDICATION ORDERS

☐ Dosing: 210mg SC every month

Patient is currently taking Calcium/Vitamin D Supplement ☐ Yes ☐ No

Has the patient had any fractures? ☐ Yes ☐ No

DIAGNOSIS/INDICATION

☐ M81.0 Age-related osteoporosis without current pathological fracture
☐ M81.8 Other osteoporosis without current pathological fracture
☐ Other (please specify in notes)

***ICD-10** _____ **required**

_____ _____
Ordering Provider's Signature Date

NOTES (ADDITIONAL INFO)

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

PLEASE ATTACH THE FOLLOWING REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ Serum Calcium (w/in 1year) ☐ DEXA Results (w/in 2 years) ☐ Vitamin D 25-OH (if available)

APPOINTMENT DATE & TIME _____

FOR OFFICE USE ONLY