

EVENITY ORDER FORM

Date: _____

ICD-10 Code: _____

Patient Name: _____

Allergies: _____

Date of Birth: _____

Weight: _____ lbs OR _____ kg

Therapy Status

Provider Information

New Start

Ordering Provider: _____

Continuing Therapy:
Last Dose: _____

Provider NPI: _____

Provider Phone: _____

Provider Fax: _____

Provider Address: _____

MEDICATION ORDER

Evenity Administer Evenity 210mg subcutaneously monthly for a total of 12 doses.

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first injection:

Serum calcium within 60 days prior to start of treatment.

Hypocalcemia should be corrected before initiating Evenity. Hypocalcemia may worsen, especially in patients with renal impairment. Patients should supplement adequately with calcium and vitamin D.

PRE-MEDICATIONS

Oral

- Acetaminophen: _____ 325mg _____ 500mg _____ 650mg
- Loratadine: 10mg
- Cetirizine: 10mg
- Diphenhydramine: _____ 25mg _____ 50mg
- Famotidine: _____ 20mg _____ 40mg
- Ibuprofen: _____ 200mg _____ 400mg _____ 600mg
- Ondansetron: _____ 4mg _____ 8mg
- Other: _____

IV

- Dexamethasone: _____ 4mg _____ 8mg
- Diphenhydramine: _____ 25mg _____ 50mg
- Famotidine: _____ 20mg _____ 40mg
- Methylprednisolone: 125mg
- Hydrocortisone: 100mg
- Ondansetron: _____ 4mg _____ 8mg
- Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

Surveillance lab ordering and monitoring is the responsibility of the prescriber

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

Substitution Allowed:

Prescriber Name

Date

Prescriber Name

Date