**TwelveStone Health Partners**
**Fax Referral To: (615) 278-3355**
**Direct Phone: (844) 893-0012**
**Email: referral@12stonehealth.com**

# EVENITY ORDER FORM

Patient Name: _____ ICD-10 Code: _____

Date of Birth: _____ Allergies: _____

Weight: _____ lbs OR _____ kg

**Therapy Status**

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

## PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

## MEDICATION ORDER

**Evenity**

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

✓ *Prescriber has discussed potential cardiovascular risk factors and patient has not experienced a myocardial infarction or cerebrovascular accident within the past year*

***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)

**Surveillance lab ordering and monitoring is the responsibility of the prescriber**

## 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

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

*By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.*

_____ _____

Prescriber Signature Date