

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com



EVENTY ORDER FORM

Date: _____ ICD-10 Code: _____
 Patient Name: _____ Allergies: _____
 Date of Birth: _____ 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

Eventy

- ✓ Administer Eventy 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 Eventy. 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)

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.

Dispense as Written: _____

 Prescriber Signature _____ Date _____

Substitution Allowed: _____

 Prescriber Signature _____ Date _____