

**TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com

**EVENITY ORDER FORM**

|                      |                               |                                                                        |
|----------------------|-------------------------------|------------------------------------------------------------------------|
| Date: _____          | ICD-10 Code: _____            | <b>Therapy Status</b>                                                  |
| Patient Name: _____  | Allergies: _____              | <input type="checkbox"/> New Start                                     |
| Date of Birth: _____ | Weight: _____ lbs OR _____ kg | <input type="checkbox"/> Continuing Therapy: _____<br>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)**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:

Substitution Allowed:

Prescriber Signature

Date

Prescriber Signature

Date