



Phone:616-954-0600 Fax: 616-954-1675

**Eventy Injection**

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

**Referral status:**  NEW referral  Dose or frequency change  Order renewal

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Allergies: \_\_\_\_\_ Patient Weight: \_\_\_\_\_ lbs / kg Height: \_\_\_\_\_

Diagnosis :  Osteoporosis, please specify ICD-10 code: \_\_\_\_\_  
 Other: please specify: \_\_\_\_\_

Attach most recent DEXA scan results: Date: \_\_\_\_\_ T-Score: \_\_\_\_\_

Has the

In the past year, what medications for the above diagnosis has the patient tried and failed?

N/A continuation of treatment

Drug	Dose	Dates of use

Does patient have a diagnosis or history of any of the following (check all that apply)?:

- Hypocalcemia
- History of hypoparathyroidism
- Thyroid or parathyroid surgery
- Severe renal impairment (CrCl<30)
- Malabsorption syndromes
- Recurrent UTI
- Recent tooth extraction or jaw surgery
- NO** the patient does **NOT** have history of any of the above

**Eventy (romosozumab-aqqg) 210 mg subcutaneous injection**  
**Every month for total of 12 doses per year**

Serum calcium required within **2 months** of first appointment  
Result date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Lab Result : \_\_\_\_\_  
*Contraindicated in patients with hypocalcemia*

Printed provider name: \_\_\_\_\_

Provider signature: \_\_\_\_\_

Office phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_