

Infusion Order Form

Patient Information:

Patient Name

DOB

Phone Number

Medical Information:

Primary Diagnosis:

Age-related Osteoporosis without current fracture

ICD-10 Code: M81.0

Age-related Osteoporosis with current fracture

ICD-10 Code: M80.0

Other _____

ICD-10 Code: _____

Allergies: _____ (or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
 - Currently receiving Calcium/Vitamin D supplementation:
 - Yes No Other: _____
- Required Information:
 - DXA scan within 2 years
 - Recent serum calcium within 3 months

Height: _____
Weight: _____

Evenity (romosozumab-aqqg) Orders:

Administer 210 mg subcutaneously monthly for 12 total doses*

*Each 210 mg dose will require two syringes (105 mg/1.17 mL each)

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders: Serum calcium level every ____ months

Other: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

Prescriber's Signature

Date

Prescriber's Printed Name

Contact Phone #:

Please fax the completed order form and all other requested information to: 601-714-1569

For Information About Revitalize and or Infusion Plus, please scan the QR code below:



Revitalize



Revitalize Locations



InfusionPlus