EVENITY®
(romosozumab-aqqg)
injection 105 mg/1.17 mL

Treatment Referral Form

Fax Form to: 330-294-2082

INDY INFUSION

❑ Dear Doctor/Medical Office:
I am referring my patient to you for administration of EVENITY® injection (210 mg subcutaneous in the upper arm, upper thigh, or abdomen once every month).

Treatment Site Information

Physician Name: _____ Specialty: _____ Site Name: _____
Address: _____ City: _____ State: _____ ZIP Code: _____
Phone: _____ Fax: _____ Office Contact: _____

Patient Information

Fill out entirely OR ❑ **attach Face/Demographic Information Sheet**

Patient Name: _____ Date of Birth: _____ Social Security Number: _____ M❑ F❑
Address: _____ City: _____ State: _____ ZIP Code: _____
Work Phone: _____ Cell Phone: _____ Email: _____

Insurance Information

Fill out entirely OR ❑ **fax a copy of Insurance card front AND back.**

Primary Insurance: _____ Secondary Insurance: _____
Insured: _____ Insured: _____
Phone: _____ Phone: _____
Policy #: _____ Email: _____

Patient Medical Information*

❑ M81.0 (Age-related osteoporosis without current pathological fracture)
❑ M80.0 _____ (Age-related osteoporosis with current pathological fracture)
Please provide complete code (see next page for details).
❑ Original diagnostic T-score: _____ Date: _____
❑ Other (specify ICD-10 Code): _____
Please provide secondary ICD-10 Code, if applicable: _____
❑ History of osteoporotic fracture

Prior Osteoporosis Therapy (if any):

❑ Generic alendronate ❑ Fosamax® (alendronate sodium) ❑ Actonel® (risedronate sodium) ❑ Boniva® (ibandronate sodium) ❑ Tymlos® (abaloparatide)
❑ Forteo® (teriparatide) ❑ Other (specify): _____
Reason for discontinuing previous osteoporosis therapy(ies): _____
Contraindications (if any): _____
Patient is currently taking calcium and vitamin D supplements: ❑ Yes ❑ No Calcium level available: ❑ Yes ❑ No
Other pertinent information: _____

** A copy of this information can be given to the patient to bring to his/her appointment. The sample diagnosis codes are informational and not intended to be directive or a guarantee of reimbursement and include potential codes that would include FDA-approved indications for EVENITY®. Other codes may be more appropriate given internal system guidelines, payer requirements, practice patterns, and the services rendered.*

Physician Information

Physician Name: _____ NPI #: _____ Specialty: _____ Site Name: _____
Address: _____ City: _____ State: _____ ZIP Code: _____
Phone: _____ Fax: _____ Office Contact: _____

Product Information

Product Name/Strength: EVENITY® 210 mg
Directions: 210 mg SC every month for 12 months
Prescriber Signature: X _____ Date: _____

Administering Healthcare Professional's Comments: _____

*Please attach any labs and clinical information that relates to the request for Evenity.

Indy Infusion is a product of Independence Visiting Primary Care