



**Birmingham, AL**  
F: 205-271-9971

**Huntsville, AL**  
F: 256-417-6408

**Knoxville, TN**  
F: 865-934-0249

**Nashville, TN**  
F: 615-645-4791

**Chantilly, VA**  
F: 703-935-2061

**PREVIOUS ADMINISTRATION**

Please provide the following information: Last Infusion Date: \_\_\_\_\_ Next Infusion Date: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Is the patient Diabetic: Y N ICD-10 Code: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Primary Diagnosis:** \_\_\_\_\_ Age-related Osteoporosis with current fracture  
 \_\_\_\_\_ Age-related Osteoporosis without current fracture  
 \_\_\_\_\_ Other: \_\_\_\_\_

Please attach the following: 1. Clinical MD Notes, labs, test supporting primary diagnosis, Any recent history of heart attack or stroke in the past year. 2. Documentation of therapies previously trialed and failed 3. Dexa Scan Results indicating osteoporosis 4. Recent serum calcium 5. Recent dental exam results 6. Current medication list: Patient is currently receiving calcium/vitamin D supplementation: Yes No Other: \_\_\_\_\_, Was the patient previously receiving a bisphosphonate: Yes No , If yes, therapy was discontinued: \_\_\_\_\_, If yes, desired wash-out period prior to starting Evenity: \_\_\_\_\_ weeks 7. Copy of patients Insurance Card

**Physician Information**

Prescribing Physician: \_\_\_\_\_ Practice Name: \_\_\_\_\_  
 Practice Phone: \_\_\_\_\_ Practice Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Co-managing Physician: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

**Medication Order**

**Medication: EVENITY® (romosozumab-aqqg)**  
**Evenity 210 mg once monthly**

**New Start:** \_\_\_\_\_ # Refills (Recommend 11 Refills)  
 Administer 210 mg subcutaneously each month  
 ▪ Each dose will require two syringes (105 mg/1.17 mL each)

**Pre-Medication Orders:**  
 Acetaminophen 650 mg PO administered 30 min prior to infusion \*adjust to patient’s needs  
 Other: \_\_\_\_\_

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.

**By signing below, I certify that above therapy is medically necessary. Prescriber’s Signature (SIGN BELOW)**  
 By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

\_\_\_\_\_  
 Physician’s NPI# Physician’s Address  
 \_\_\_\_\_  
 Prescriber’s Signature Date

Legal Notice: The prescriber is to comply with their state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the recipient named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. This prescription may be filled out at a pharmacy of the patient’s choice. ©2025 ContinuumRx Services, Inc. All rights reserved.