OKLAHOMA
INFUSION SERVICES

1701 Renaissance Blvd, Ste. 110
Edmond, OK 73013-5853
Phone: (405) 844-4978; Fax: (405) 844-0562

Evenity Order Form

Patient's Information

Patient's Name:	**Patient's Date of Birth:**	**Patient's Phone:**	**Gender:** M ☐ F ☐
Patient's Address:	**Patient's Email:**	**Insurance:**	

Additional Information

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ M80.0 Age-related Osteoporosis with Current Pathological Fracture
☐ M81.0 Age-Related Osteoporosis without Current Pathological Fracture
☐ Other: Code: ___________ Description: ____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: ___________ lbs / ___________ kg ☐ Patient Height: ___________ in / ___________ cm
☐ Allergies: ____
☐ Therapies Tried and Failed: ____
☐ Patient currently taking Calcium and Vitamin D supplement? ☐ Yes ☐ No
☐ Patient has history of fractures? ☐ Yes ☐ No
☐ DEXA Test: Date: ___________ Results: ____
☐ TB Test: Date: ___________ Results: ___________ ☐ Hep B Test: Date: ___________ Results: ___________

Lab Orders

☐ Lab Orders: ☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ HBsAg ☐ HBsAB ☐ HBcAB ☐ Quantiferon Gold
☐ Lab Orders to be drawn by: ☐ Oklahoma Infusion Services ☐ Referring Provider

Prescription Information

☐ Evenity	☐ Dose: 210mg (Two 105mg injections) Frequency: ☐ once every month for 12 months

Pre-Medication Orders

☐ Solu-Cortef 50-100mg SIVP ☐ Benadryl 25mg PO PRN
☐ Tylenol tablet 500-1000mg PO PRN ☐ No routine premedication necessary

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus ☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Notify supervising physician and ordering provider ☒ Oxygen 2-5L nasal cannula
☒ Solu-Cortef 100mg SIVP signs of adverse reaction ☒ Albuterol 2.5mg inhaled PRN for chest tightness
☒ Benadryl 25mg SIVP for hives or bronchial inflammation ☐ Other: ___________________________

Prescriber's Information		**Prescriber's Contact Person**
Prescriber's Name:		**Contact Name:**
NPI #:	**DEA #:**	**Contact Phone:**
Prescriber's Signature:		**Contact Fax:**
Date:		

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.