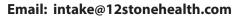
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





EVENITY ORDER FORM				
Date: ICD-10 Code:			Therapy Status	
		Allergies:		☐ New Start
Date of Birth:				☐ Continuing Therapy: Last Dose:
PROVIDER INFORMATION				
Ordering Provider: Provider:				
Provider NPI:		Provider Address:_		
Provider Phone:				
MEDICATION ORDER				
WIEDIOATION ONDER				
Evenity	✓ Administer Evenity 210mg subcutaneously monthly for a total of 12 doses.			Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first injection: ✓ Serum calcium within 60 days prior to start of treatment. **Hypocalcemia should be corrected before initiating Evenity. Hypocalcemia may worsen, especially in patients with renal impairment. Patients should supplement adequately with calcium and vitamin D.**
PRE-MEDICATIONS				
Oral □ Acetaminophen: 325mg 500mg 650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine: 25mg 50mg □ Famotidine: 20mg 40mg □ Ibuprofen: 200mg 400mg 600mg □ Ondansetron: 4mg 8mg □ Other:				
LAB ORDERS (please indicate any labs to be drawn and frequency)			OTH	IER REQUIRED DOCUMENTATION
Surveillance lab ordering and monitoring is the responsibility of the prescriber By signing below, I certify that the above therapy is med By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as m to payors with respect to this patient and prescription order. This enrollmen Dispense as Written:			ny designated agent in submitting prior authorizations and other clinically required information	
Prescriber	Name	 Date	 Prescriber Nam	ne Date