TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: intake@12stonehealth.com

EVENITY ORDER FORM

Date: ______________________ ICD-10 Code: ______________________

Patient Name: ______________________ Allergies: ______________________

Date of Birth: ______________________ Weight: ________ lbs OR ________ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: ______________________

PROVIDER INFORMATION

Ordering Provider: ______________________ Provider Fax: ______________________

Provider NPI: ______________________ Provider Address: ______________________

Provider Phone: ______________________

MEDICATION ORDER

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: ______________________

IV

☐ Dexamethasone: ______ 4mg ______ 8mg

☐ Diphenhydramine: ______ 25mg ______ 50mg

☐ Famotidine: ______ 20mg ______ 40mg

☐ Methylprednisolone: 125mg

☐ Hydrocortisone: 100mg

☐ Ondansetron: ______ 4mg ______ 8mg

☐ Other: ______________________

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature *(SIGN BELOW)*

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written:	Substitution Allowed:
Prescriber Name ______________ Date ______________	Prescriber Name ______________ Date ______________

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