



TALIS HEALTHCARE  
AN INFUSION MANAGEMENT COMPANY

**EVENITY®**

Please Fax Completed Form To: **888-898-9113**

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

Please Send a Copy of The Patient's Up-to-Date Clinical Notes

| PATIENT INFORMATION (Complete or Fax Existing Chart)                                                                                                                                        |  | PRESCRIBER INFORMATION                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|
| Name: _____ DOB: _____                                                                                                                                                                      |  | Prescriber Name: _____                                                                                                             |  |
| Address: _____                                                                                                                                                                              |  | State License: _____                                                                                                               |  |
| City, State, Zip: _____                                                                                                                                                                     |  | NPI #: _____ DEA: _____                                                                                                            |  |
| Phone: _____ Alt. Phone: _____                                                                                                                                                              |  | Address: _____                                                                                                                     |  |
| Email: _____ SS#: _____                                                                                                                                                                     |  | City, State, Zip: _____                                                                                                            |  |
| Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____                                                                                                 |  | Phone: _____ Fax: _____                                                                                                            |  |
| Allergies: _____                                                                                                                                                                            |  | Office Contact: _____ Phone: _____                                                                                                 |  |
| INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)                                                                                      |  |                                                                                                                                    |  |
| Primary Insurance: _____                                                                                                                                                                    |  | Secondary Insurance (If Applicable): _____                                                                                         |  |
| Plan #: _____                                                                                                                                                                               |  | Plan #: _____                                                                                                                      |  |
| Group #: _____                                                                                                                                                                              |  | Group #: _____                                                                                                                     |  |
| RX Card (PBM): _____                                                                                                                                                                        |  | RX Card (PBM): _____                                                                                                               |  |
| BIN: _____ PCN: _____                                                                                                                                                                       |  | BIN: _____ PCN: _____                                                                                                              |  |
| CLINICAL INFORMATION                                                                                                                                                                        |  |                                                                                                                                    |  |
| <input type="checkbox"/> M81.8 Osteoporosis, unspecified <input type="checkbox"/> M81.00 Osteoporosis without pathological fracture <input type="checkbox"/> Other (specify ICD-10): _____  |  |                                                                                                                                    |  |
| T-Score (If known): _____                                                                                                                                                                   |  |                                                                                                                                    |  |
| History of osteoporotic fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No Skeletal Site (If known): _____                                                                  |  |                                                                                                                                    |  |
| Has the patient failed or is unable to tolerate bisphosphonate therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                            |  |                                                                                                                                    |  |
| ➤ If yes, please explain: _____                                                                                                                                                             |  |                                                                                                                                    |  |
| Does the patient have >1 risk factor for fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                 |  |                                                                                                                                    |  |
| ➤ If yes, please explain: _____                                                                                                                                                             |  |                                                                                                                                    |  |
| Reason for discontinuing previous osteoporosis therapies: _____                                                                                                                             |  |                                                                                                                                    |  |
| Calcium level: _____ Date lab drawn: _____                                                                                                                                                  |  |                                                                                                                                    |  |
| TRIED AND/OR FAILED MEDICATIONS                                                                                                                                                             |  | LENGTH OF THERAPY                                                                                                                  |  |
| _____ / _____                                                                                                                                                                               |  | _____ / _____                                                                                                                      |  |
| _____ / _____                                                                                                                                                                               |  | _____ / _____                                                                                                                      |  |
| REASON FOR DISCONTINUATION                                                                                                                                                                  |  |                                                                                                                                    |  |
| _____                                                                                                                                                                                       |  |                                                                                                                                    |  |
| EVENITY® ORDERS                                                                                                                                                                             |  |                                                                                                                                    |  |
| Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection: _____ |  |                                                                                                                                    |  |
| Medication                                                                                                                                                                                  |  | Directions                                                                                                                         |  |
| <input type="checkbox"/> Evenity® (Romosozumab) 105mg/1.17 mL prefilled syringes (two-pack)                                                                                                 |  | Inject 210 mg (two 105 mg syringes sequentially) subcutaneously once every month for 12 doses in the abdomen, thigh, or upper arm. |  |
| Quantity/Refills                                                                                                                                                                            |  |                                                                                                                                    |  |
| <input type="checkbox"/> 1 Carton (2 Syringes)<br><input type="checkbox"/> Other: _____<br>Refills: _____                                                                                   |  |                                                                                                                                    |  |
| Pre-Medication                                                                                                                                                                              |  | Dose/Strength                                                                                                                      |  |
| <input type="checkbox"/> Acetaminophen                                                                                                                                                      |  | <input type="checkbox"/> 500mg                                                                                                     |  |
| <input type="checkbox"/> Diphenhydramine                                                                                                                                                    |  | <input type="checkbox"/> 25mg IV/PO<br><input type="checkbox"/> 50mg IV/PO                                                         |  |
| <input type="checkbox"/> Methylprednisolone                                                                                                                                                 |  | <input type="checkbox"/> 40mg <input type="checkbox"/> 125mg                                                                       |  |
| <input type="checkbox"/> _____                                                                                                                                                              |  | _____                                                                                                                              |  |
| Directions                                                                                                                                                                                  |  |                                                                                                                                    |  |
| <input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed                                                                                                 |  |                                                                                                                                    |  |
| <input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR                                                                                                               |  |                                                                                                                                    |  |
| <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed                                                                                                      |  |                                                                                                                                    |  |
| <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed                                                                                                      |  |                                                                                                                                    |  |
| <input type="checkbox"/> _____                                                                                                                                                              |  |                                                                                                                                    |  |

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## INFUSION REACTION ORDERS

### Mild reaction protocol:

☒ Diphenhydramine 25mg IV, one time, for pruritus.

*If symptoms worsen, see orders for moderate to severe reactions.*

### Moderate reaction protocol:

☒ Acetaminophen 650mg PO, one time, for pyrexia or rigors

☒ Diphenhydramine 50mg IV, one time, for pruritus or urticaria

☒ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

*If symptoms worsen, see interventions for severe reactions*

### Severe reaction protocol: (Call 911 if initiated):

☒ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)

☒ Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

☒ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

☒ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms

☒ Epinephrine 0.3mg/0.3mL IM into mid-antrolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

## FLUSHING & LOCKING ORDERS

### Flushing Protocol (>66lbs/33kg)

#### PIV and Midline:

☒ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion

#### Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:

☒ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

### Locking Protocol (>66lbs/33kg)

#### PIV and Midline:

☒ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush

#### PICC:

☒ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush

#### Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:

☒ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**\*\* May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

## SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral

X \_\_\_\_\_

Prescriber Signature

Date: \_\_\_\_\_

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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