EVENITY ENROLLMENT FORM

PATIENT INFORMATION *(Complete the following or send patient's demographic sheet)*

Last Name ______ First Name ______ Sex □ M □ F ______ Date of Birth

Address ______ Home Phone ______ Work/Mobile Phone ______

Medicare # ______ Medical # ______ Other ______ Facility ______

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD-10 code): □ **Through Medical Benefits**

□ M81.0 Age-related osteoporosis without current pathological fracture

□ M80.0 Age-related osteoporosis with current pathological fracture □ Other:______

- Is Patient pregnant, nursing, or planning pregnancy? □ Yes □ No □ N/A | Allergies: ______

Patient Evaluation:

- Is the patient currently taking a bisphosphonate? □ Yes □ No
  If Yes, will current bisphosphonate therapy be discontinued? □ Yes □ No
- Patient is currently taking Calcium and Vitamin D Supplements □ Yes □ No
- Does the patient have hypocalcemia? □ Yes □ No • Patient's Weight: ______Kgs/lbs.
- Is the patient at the risk of fracture? □ Yes □ No • Patient's height: ______ inches

Bone Mineral density Results:

- DXA Results (g/cm2):______ Original T-Score: ______ Date: ______

Prior Failed Medications:

□ Generic Alendronate □ Fosamax □ Actonel □ Boniva □ Other ______

Reason for discontinuation of other therapy(ies) ______

Contraindications (if any) ______

PRESCRIPTION INFORMATION

MEDICATION	DIRECTIONS	QUANTITY	REFILL
☐ EVENITY	Inject 210mg SubQ once every month	1	11

Prescriber Certification: I certify the above therapy is medically necessary and that the information above is accurate to the best of my knowledge I authorize the Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: X______ **Date:**______ **Office contact:**______

Physician Name:______ **UPIN #**______ **NPI #**______ **DEA#**______

Physician Address:______ **Phone #**______ **Fax** ______

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual only for the individual named. If you are not the named addresse, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake. Then destroy this document. Please direct all verification or notification to the above mentioned physician's office.

By signing this document you authorize Southside pharmacy to contact insurance companies for prior authorization purposes.

FAX TO : (855) 822-7838

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