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** _____

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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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