



Please Fax Completed Form To: 888-898-9113

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

	lete or Fax Existing Chart	PRESCRIBER INFORMATION						
Name:								
Address:		State License: DEA:						
City, State, Zip:								
Phone: Alt. I		City, State, Zip:						
Email:		- '						
Gender: M F Weight:		Office Contact:						
Allergies:								
INSURANCE INFORMATION – A	ND – Send a copy of the p	patient's prescription/insurance cards	(front & back)					
Primary Insurance:		Secondary Insurance (If Applicable):						
Plan #:		Plan #:						
Group #:								
RX Card (PBM):		RX Card (PBM):						
BIN: P								
CLINICAL INFORMATION								
	M81 00 Osteonorosis without	: pathological fracture \Box Other (specify ICD-1	(A):					
T-Score (If known):		pathological mastare — other (specify leb 1						
		vn):						
Has the patient failed or is unable to to	·							
☐ If yes, please explain:		. 1163 1110						
Does the patient have >1 risk factor for								
☐ If yes, please explain: ☐								
			Reason for discontinuing previous osteoporosis therapies:					
TRIED AND/OR FAILED MEDICATIONS LENGTH OF THERAPY REASON FOR DISCONTINUATION								
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EVENITY® ORDERS	ATIONS LENGT	TH OF THERAPY REA	SON FOR DISCONTINUATION					
EVENITY® ORDERS	Restart							
EVENITY® ORDERS								
EVENITY® ORDERS Prescription type: Medication	Restart	y Total Doses Received: Dat	te of Last Injection:Quantity/Refills					
EVENITY® ORDERS Prescription type: □ New start □ I Medication □ Evenity® (Romosozumab) 105mg/1.	Restart	y Total Doses Received: Dat Directions g syringes sequentially) subcutaneously once ex	te of Last Injection:Quantity/Refills					
EVENITY® ORDERS Prescription type: Medication	Restart	y Total Doses Received: Dat	te of Last Injection:					
EVENITY® ORDERS Prescription type: □ New start □ I Medication □ Evenity® (Romosozumab) 105mg/1.	Restart	y Total Doses Received: Dat Directions g syringes sequentially) subcutaneously once ex	te of Last Injection: Quantity/Refills Guantity/Refills Cery Other: Refills:					
EVENITY® ORDERS Prescription type: □ New start □ I Medication □ Evenity® (Romosozumab) 105mg/1. mL prefilled syringes (two-pack) Pre-Medication	Restart	y Total Doses Received: Dat Directions g syringes sequentially) subcutaneously once exabdomen, thigh, or upper arm.	te of Last Injection: Quantity/Refills 1 Carton (2 Syringes) Other: Refills:					
EVENITY® ORDERS Prescription type: New start Medication Evenity® (Romosozumab) 105mg/1. mL prefilled syringes (two-pack) Pre-Medication Acetaminophen	Restart	y Total Doses Received: Dat Directions g syringes sequentially) subcutaneously once exabdomen, thigh, or upper arm. Direction	te of Last Injection: Quantity/Refills 1 Carton (2 Syringes) Other: Refills: ss-t-infusion as directed					
EVENITY® ORDERS Prescription type: New start Medication Evenity® (Romosozumab) 105mg/1. mL prefilled syringes (two-pack) Pre-Medication Acetaminophen	Restart	y Total Doses Received: Dat Directions g syringes sequentially) subcutaneously once exabdomen, thigh, or upper arm. Direction Take 1-2 tablets PO prior to infusion or pos	te of Last Injection: Quantity/Refills I Carton (2 Syringes) Other: Refills: ss st-infusion as directed ected OR					
EVENITY® ORDERS Prescription type: New start Medication Evenity® (Romosozumab) 105mg/1. mL prefilled syringes (two-pack) Pre-Medication Acetaminophen Diphenhydramine	Restart	y Total Doses Received: Dat Directions g syringes sequentially) subcutaneously once exabdomen, thigh, or upper arm. Direction Take 1-2 tablets PO prior to infusion or as direction	te of Last Injection: Quantity/Refills I Carton (2 Syringes) Other: Refills: st-infusion as directed ected OR or as directed					

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INFUSION REACTION ORDERS					
Mild reaction protocol:					
☑ Diphenhydramine 25mg IV, one time, for pruritu	JS.				
If symptoms worsen, see orders for moderate to sev	vere reactions.				
Moderate reaction protocol:					
Acetaminophen 650mg PO, one time, for pyrexia or rigors					
☑ Diphenhydramine 50mg IV, one time, for pruritus or urticaria					
oxtimes Methylprednisolone 125mg IV, one time, for res	piratory or neurologic syn	nptoms			
lf symptoms worsen, see interventions for severe re	eactions				
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					
oxtimes Methylprednisolone 125mg IV, one time, for res	piratory symptoms, edem	ia, or anaphylaxis			
oxtimes Sodium Chloride 0.9% 500mL IV over 30-60 min,	, one time, for cardiovascu	ılar symptoms			
☑ Epinephrine 0.3mg/0.3mL IM into mis-anterolat	eral aspect of thigh of ana	phylaxis, may repeat x1 in	5-15 minutes if symptoms are not resolved or		
worsen					
FLUSHING & LOCKING ORDERS					
Flushing Protocol (>66lbs/33kg)					
PIV and Midline:		Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:			
☑ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion		☑ 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:	PICC:		Implanted Port, Tunneled Catheter, and Non-		
□ Heparin Sodium 10 units/mL 1mL IV final	☐ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush		tunneled Catheter:		
flush post normal saline flush			☐ Heparin Sodium 100 units/mL 3-5mL IV final		
		handada da bara	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 bring 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		Date:
	Prescriber Signature	

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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