INFUSION CENTER OF NEW ENGLAND

Checklist for EVENITY or PROLIA Referral

Patient Name: _____ DOB: _____ Date: _____

Referring Physician: _____NPI:_____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ❑ Patient demographic information
- ❑ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ❑ Supporting clinical notes and office visits. Two notes preferred.
  - Note should include any therapies tried/failed, and must include discussion about Evenity / Prolia
  - Medication list and allergies
  - **All patients should be supplemented with calcium 1000 mg daily and at least 400 IU vitamin D daily**
- ❑ Supporting lab reports/imaging for Evenity / Prolia treatment
  - Serum calcium and vitamin D levels at baseline and continual monitoring
  - Serum evaluation of kidney function at baseline and continual monitoring: BUN/Cr, GFR
- ❑ Evenity / Prolia Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible –

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 option 4

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterne.com

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

Prescribing Order: Evenity (romosozumab) / Prolia (denosumab)

Date of Order: _____ ❑ New Start ❑ Maintenance
Date of last injection: _____

Patient Name: _____ **DOB:** _____ **M/F:** ____

Diagnosis (include ICD-10 code/s): _____

❑ **NKDA** **Allergies:** _____

Premedication:

❑ Acetaminophen 1000mg PO
❑ Loratadine 10mg or Cetirizine 10mg PO
❑ Diphenhydramine 25mg PO
❑ Other: _____

Medication Order

- ❑ **EVENITY 105mg/1.17ml x2 - Total dose 210mg**
  - ❑ Monthly x 12 months
  - ❑ Other: _____
- ❑ **PROLIA 60mg/1ml** (or biosimilar as required by patient's insurance)
  - ❑ Every 6 months
    Other: _____

Administration:

- ✓ Administer Evenity / Prolia (or biosimilar) as a subcutaneous injection/s in the thigh, abdomen, or upper arm
- ✓ Do not administer if patient has active signs or symptoms of infection.
- ✓ In case of reaction, follow NCNE infusion reaction protocol. Notify physician.

Ordering Provider Name **NPI**

Signature **Date**

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