

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
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Allergies:	Date of Referral:
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REFERRAL STATUS

New Referral Dose or Frequency Change Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* Mattoon Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

<input type="checkbox"/> Age related Osteoporosis without current pathological fracture	ICD 10 Code: M81.0
<input type="checkbox"/> Age related Osteoporosis with current pathological fracture	ICD 10 Code: M80.0 _____
<input type="checkbox"/> Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes (must be within 1 year)
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Calcium within 2 weeks of injection	<input type="checkbox"/> DEXA scan results and/or FRAX score
<input type="checkbox"/> Vit D, BMP within 45 days of dose	<input type="checkbox"/> Documentation of oral hygiene

*Patient may be required to submit a pregnancy test prior to treatment

List Tried & Failed Therapies, including duration of treatment:

- 1)
- 2)
- 3)

MEDICATION ORDERS

Dosing Wt for Calculations	Ht:	Wt (in kg):	BMI:
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Dosing	<input type="checkbox"/> J3111 Evenity 210mg SubQ once monthly (given as two injections of 105mg each)
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Duration	<input type="checkbox"/> X 6 months	<input type="checkbox"/> X 1 year	<input type="checkbox"/> _____ doses
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ADDITIONAL ORDERS / INFORMATION

*Evenity is only recommended for 12 doses.

PRESCRIBER INFORMATION

Prescriber name :	Office Phone:	Office Fax:	Office Email:
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Prescriber Signature:	Date:	Time:
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All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:	<input type="checkbox"/> MATTOON 1000 Health Center Dr. Ph. 217-258-4150 Fax Completed Form and all documentation to: Suite 204 Mattoon, IL 61938	<input type="checkbox"/> EFFINGHAM 901 Medical Park Dr. Ph. 217-342-7500 Suite 201 Effingham, IL 62401
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