



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ DEA: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION

M81.8 Osteoporosis, unspecified M81.00 Osteoporosis without pathological fracture Other (specify ICD-10): _____

T-Score (If known): _____

History of osteoporotic fracture? Yes No Skeletal Site (If known): _____

Has the patient failed or is unable to tolerate bisphosphonate therapy? Yes No

↳ If yes, please explain: _____

Does the patient have >1 risk factor for fracture? Yes No

↳ 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

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection: _____

Medication	Directions	Quantity/Refills
<input type="checkbox"/> Evenity® (Romosozumab) 105mg/1.17 mL prefilled syringes (two-pack)	Inject 210 mg (two 105 mg syringes sequentially) subcutaneously once every month for 12 doses in the abdomen, thigh, or upper arm.	<input type="checkbox"/> 1 Carton (2 Syringes) <input type="checkbox"/> Other: _____ Refills: _____

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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