TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

EVENITY®

Please Fax Completed Form To: 888-898-9113

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

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

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

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

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

EVENITY® ORDERS

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

Medication	Directions	Quantity/Refills
☐ 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.	☐ 1 Carton (2 Syringes) ☐ 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.