

**Borough Park**  
1428 36th Street  
Suite 107  
Brooklyn, NY 11218

**Crown Heights**  
555 Lefferts Avenue  
Brooklyn, NY 11225

**Manhattan**  
57W 57Street  
Suite 601  
New York, NY 10019



**Queens**  
64-05 Yellowstone Blvd  
CF104  
Forest Hills, NY 11375

**Riverhead**  
1228 E Main Street  
Suite A  
Riverhead, NY 11901

**Manhasset**  
333 East Shore Road  
Suite 201  
Manhasset, NY 11030

**Rockville Centre**  
165 North Village Avenue  
Suite 133  
Rockville Center, NY 11570

**Elmsford/ Terrytown**  
555 Taxter Road  
3rd Floor  
Elmsford, NY 10523

**Holbrook/ Ronkonkoma**  
233 Union Ave  
Suite 207  
Holbrook, NY 11741

**Scarsdale**  
495 Central Park Avenue  
Suite 205  
Scarsdale, NY 10583

# MEDICATION ORDERS EVENTY ROMOSOZUMAB(aqqg)

Date: \_\_\_\_\_



PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

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	ICD10 Code: M81.0
<input type="checkbox"/> Age related Osteoporosis with current pathological fracture	ICD10 Code: M8 0.0
<input type="checkbox"/> Other Diagnosis: _____	ICD10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Serum calcium level	<input type="checkbox"/> DEXA scan results and/or FRAX score
<input type="checkbox"/> Documentation of oral hygiene	
List Tried & Failed Therapies, including duration of treatment (please comment specifically on bisphosphonates) :	
1)	
2)	

MEDICATION ORDERS	
Dosing	<input type="checkbox"/> Eventy 210mg SubQ once monthly (given as two injections of 105mg each)
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

## ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_