



**MATAGORDA REGIONAL**  
MEDICAL CENTER

MPMC IV THERAPY  
SERVICES PHONE:  
979-241-5966  
FAX: 979-241-5965

**EVENTY(ROMOSOZUMAB-AQQG) ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_  
HT: \_\_\_\_\_ WT: \_\_\_\_\_ Sex : ( ) Male ( ) Female SSN: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_  
Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Allergies: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Name \_\_\_\_\_ Policy ID #: \_\_\_\_\_  
Secondary Insurance Name \_\_\_\_\_ Policy ID #: \_\_\_\_\_

**PHYSICIAN / FACILITY INFORMATION**

Physician Name \_\_\_\_\_ Contact Name \_\_\_\_\_ Contact Phone # \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
DEA#: \_\_\_\_\_ NPI #: \_\_\_\_\_ State Lic #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD-10 CODE) \_\_\_\_\_  
Date of Diagnosis: \_\_\_\_\_

**PRESCRIPTION ORDERS**

**EVENTY(ROMOSOZUMAB-AQQG) 210 mg/ml, SUBCUTANEOUS  
GIVE ONCE EVERY MONTH X 1 YEAR**

**INCLUDE COPIES OF THE FOLLOWING:**

- **IONIZED CALCIUM LEVEL MUST BE CHECKED PRIOR TO THE 1ST AND 2ND DOSE THEN EVERY 3 MONTHS THEREAFTER. RENAL PANEL MUST BE CHECKED WITH 1ST DOSE THEN RE-EVALUATE AT THE TIME OF CALCIUM LEVEL IF BORDERLINE; IF NOT, THEN AT 6 MONTHS. HOSPITAL WILL COLLECT LABS PRIOR TO INJECTION IF NEEDED AND NOT AVAILABLE.**
- **LABS PRIOR TO THE FIRST DOSE MAY BE WITHIN 3 MONTHS OF THE FIRST TREATMENT.**
- **BONE DENSITY/DEXA SCAN WITHIN THE LAST 2 YEARS – OTHERWISE ONE WILL BE PERFORMED PRIOR TO THE DATE OF SERVICE BY THE ORDERING PHYSICIAN BEFORE SCHEDULING APPOINTMENT**
- **OFFICE NOTES SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS/OSTEOPENIA DATED WITHIN THE LAST 2 YEARS**
- **H+P DATED WITHIN THE LAST 2 YEARS**
- **PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS/OSTEOPENIA MUST BE DOCUMENTED IN PATIENT’S MEDICAL RECORD. Examples: Oral calcium, Vitamin D**

**Labs Needed:**

**IONIZED CALCIUM LEVEL PRIOR TO 1ST & 2ND DOSE THEN EVERY 3 MONTHS (if not already provided)**

**RENAL PANEL PRIOR TO 1ST DOSE & RE-EVALUATE AT TIME OF CALCIUM LEVEL IF BORDERLINE; IF NOT, THEN AT 6 MONTHS (if not already provided)**

Provider’s Signature : \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed 04/2026

**Fax completed form to the MPMC Infusion Center at 979-241-5965.  
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE  
INFORMATION in order for your referral to be processed.**