Cascade Infectious Diseases and Infusion

Specialty Order Form

Patient:_____	Ordering Provider:_____
DOB:_____ ☐M ☐F	NPI:_____
Height:_____ Weight:_____ lbs.	Practice:_____
Allergies:_____	Phone:_____
Diagnosis:_____	Fax:_____
ICD-10 Code(s):_____	Contact Name:_____

Has the patient been treated for this condition previously? ☐ No ☐ Yes, medication(s): _____

Is the patient currently on therapy? ☐ No ☐ Yes, medication(s): _____

☐ **EVENITY (ROMOSOZUMAB-AQQG)** 210 mg Evenity by SubQ injection every month for 12 months.

☐ **PROLIA (DENOSUMAB)** 60 mg Prolia by SubQ injection every 6 months.

If you are referring a NEW patient please refer to our website http://www.cascadeinfusion.com for the complete Specialty Medication Checklist.

Quick Checklist for returning Evenity and Prolia patients.

□ Has the patients insurance changed? If yes, include new demographic sheet and copy of insurance card(s).

□ Completed Cascade ID & Infusion Specialty Order Form

□ Signed RX

□ Recent Progress Note

□ Recent CMP

□ DEXA scan within the last 2 years

Physician's Signature:_____ **Date:**_____