

| <b>EVENITY® (ROMOSUZUMAB-AQGG) PRESCRIBER ORDER FORM</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                |                                                             |                     |                                                          |
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| <b>Patient Name:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                | <b>Date of Birth:</b>                                       |                     | <b>Gender:</b>                                           |
| <b>Address:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                |                                                             |                     |                                                          |
| <b>Phone:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | <b>Height:</b> | <input type="checkbox"/> Inches <input type="checkbox"/> cm | <b>Weight:</b>      | <input type="checkbox"/> lbs <input type="checkbox"/> kg |
| Clinical Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                |                                                             |                     |                                                          |
| <b>Primary Diagnosis Description:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                |                                                             | <b>ICD-10 Code:</b> |                                                          |
| EVENITY® (romosozumab-aqgg) Prescription                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                |                                                             |                     |                                                          |
| <input type="checkbox"/> <b>EVENITY® (Romosozumab-aqgg)</b> 210mg injected subcutaneously in the upper arm, upper thigh, or abdomen by a healthcare professional once every month. Refill x 1 year.<br><br>A full dose of EVENITY requires two single-use prefilled syringes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                |                                                             |                     |                                                          |
| Ancillary Orders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                |                                                             |                     |                                                          |
| <b>Anaphylaxis Kit</b><br>If this is a 1 <sup>st</sup> dose, would you like Option Care Health to provide an anaphylaxis kit with the 1 <sup>st</sup> dose?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> <li>Epinephrine 0.3 mg (&gt; 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (&lt; 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.</li> <li>Diphenhydramine 25 mg (&gt; 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.</li> <li>0.9% Sodium Chloride 500 mL (&gt; 30 kg) or 250mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                |                                                             |                     |                                                          |
| <b>Lab Orders</b><br><input type="checkbox"/> No labs ordered at this time.<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                |                                                             |                     |                                                          |
| Skilled nurse to assess and administer as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.<br>If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                |                                                             |                     |                                                          |
| <i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                |                                                             |                     |                                                          |
| <b>Prescriber Signature:</b> _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                |                                                             | <b>Date:</b> _____  |                                                          |
| Prescriber Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                |                                                             |                     |                                                          |
| <b>Prescriber Name:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                | <b>Phone:</b>                                               |                     | <b>Fax:</b>                                              |
| <b>Address:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                | <b>NPI:</b>                                                 |                     |                                                          |
| <b>City, State:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | <b>Zip:</b>    | <b>Office Contact:</b>                                      |                     |                                                          |
| <b>Fax completed form, insurance information, and clinical documentation to: 713-983-4647</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                |                                                             |                     |                                                          |
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