



Northwest Rheumatology Associates, P.C.  
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Telephone: (503) 297-3384 - Fax: (503) 297-0863  
www.nwrheumatology.org

## EVENTY ORDER

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient demographics, (address, phone)**

**Copy front and back of all insurance cards**

**Copy of most recent DEXA scan**

The dose of Eventy is 210mg SQ once per month for 12 months

**Prior to injection confirm the following;**

**Completed    Not required**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <b><u>Serum calcium</u></b> has been checked within 6 months and is within normal range |
| <input type="checkbox"/> | <input type="checkbox"/> | <b><u>Vitamin D</u></b> has been checked within 6 months and is greater than 30ng/ml    |
| <input type="checkbox"/> | <input type="checkbox"/> | <b><u>Complete dental exam within 3 months of treatment</u></b>                         |

**ICD-10 Code:** \_\_\_\_\_

**CPT Code:** J3111

**Expires one calendar year from date or:** \_\_\_\_\_

Ordering physician signature: \_\_\_\_\_

Ordering physician printed name: \_\_\_\_\_

**Ordering physician phone number:** \_\_\_\_\_

Ordering physician fax number: \_\_\_\_\_

***Please note all boxes must be checked off for us to schedule your patient for treatment. Please fax this information to (503) 297-0863 Attn: Patient Resource Team  
Please call with any questions at (503) 297-3384***