

Romosozumab (Evenity)

Provider Order Form rev. 2/28/23



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PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

ICD-10 code (required): _____ ICD-10 description: _____

NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

NURSING

- 0 TB status & date (list results here & attach clinicals)

- 0 Provide nursing care per 360 Infusion Center Nursing Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- Other: _____

PRE-MEDICATION ORDERS

- acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg / 50mg PO / IV
- methylprednisolone (Solu-Medrol) 40mg / 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

- Romosozumab: Inject subcutaneous injections**
 - Dose: 210mg (two 105mg syringes) / other
 - round up to nearest whole vial
 - give exact dose
 - Frequency: every 2 weeks / every 4 weeks / other:

 - Route: 0 subcutaneous
- Patient is required to stay for 30-minute observation
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

Provider Name (Print)

Provider Signature

Date