Romosozumab-aqqg (Evenity)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Post-menopausal osteoporosis:

Other: Description:

REQUIRED INFORMATION

☑ patient has NOT had an MI or stroke in the past year

☑ Recent calcium level: _____ mg/dl Date of result: _____ (please include copy)

THERAPY ADMINISTRATION

☑ Administer Evenity 210mg subcutaneously in the upper arm, abdomen, or upper thigh. Provided as 2 separate 105mg/1.17ml prefilled syringes. Rotate site with each injection.

☑ Following initial Evenity injection, observe patient for 15 minutes for hypersensitivity. Patients who have previously received and tolerated Evenity do not require observation period.

FREQUENCY *(Choose one)*

☐ Repeat once a month for 12 months

☐ Other: _____

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Hold for hypocalcemia at initiation of treatment.
- Ensure patient is taking daily calcium and vitamin D supplement.
- Planned/recent invasive dental procedures.
- Jaw, thigh or groin pain, or dermatologic changes since starting Evenity.
- A history of severe bone, muscle or joint pain following Evenity injections.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with biphosphates, Reclast, Prolia, Evenity. History of GERD, fractures, T score

Required Labs: Calcium and Vitamin D levels, Renal function

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.