Ascension Rx

Romosozumab (Evenity) Injection Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☑ Baseline
    - ☑ BMP
    - ☑ Vitamin D 25-Hydroxy
  - ☑ Maintenance (every _____)
    - ☑ BMP
    - ☑ Vitamin D 25-Hydroxy
- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____

Provider Information

Verify patient compliance/dosage of oral calcium/vitamin D supplementation. Assess for calcium abnormalities and need to modify oral calcium/vitamin D supplementation.

Confirm with the patient that a dentist/prescriber has visually inspected the oral cavity prior to initiation of therapy and is receiving ongoing evaluation for signs of osteonecrosis. Assess for jaw pain or upcoming invasive dental work.

Nursing Order

- ☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.
- ☑ Hold medication and contact physician for further instructions if calcium and/or Vitamin D levels out of normal range

Medication Orders

Medication
☑ Romosozumab-aqqg 210 mg SQ once monthly for 12 doses

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Administration Instructions

Administer into the abdomen, thigh, or outer area of upper arm. Rotate injection sites; if the same injection site is chosen, do not inject into the same spot used for the first injection. Administer two separate 105 mg injections immediately one after the other.

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated