Ascension St. Vincent's
Southside - Outpatient infusion center
Phone 904-296-5994 Fax 904-296-9070

Patient Name: _____
Date of Birth: _____
Patient Phone number: _____
Insurance: _____
Subscriber ID: _____
Infusion Site: _____

Romosozumab (Evenity) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back)
-Pertinent labs related to diagnosis and medication administration
-Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information						
Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List: _____

Referral Status

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐ Osteoporosis ☐ Other: _____	☐ M80.0 ☐ M81.0 ☐ Other: _____	☑ J3111	☑ CPT Code:

Labs (prior to scheduling infusion)

☑ Serum Calcium level ☑ Serum Albumin level ☑ Vitamin D level (25-hydroxyvitamin D) ☑ Other: _____

Nursing Orders

☑ Discharge patient when stable and meets protocol criteria
☑ Hypocalcemia and Vitamin D deficiency must be corrected prior to initiating therapy and ensure adequate calcium and vitamin D intake during therapy

Emergency/Anaphylaxis Order

☑ Follow standard orders for management of allergies and anaphylaxis reactions

Pre-medications (not required)

☐ Acetaminophen 975 mg PO, once
☐ Cetirizine 10 mg PO, once
☐ Dexamethasone 20 mg IV, once
☐ Ondansetron 4 mg IV, once
☐ Diphenhydramine 25 mg PO, once
☐ Diphenhydramine 25 mg IV, once
☐ Other:_____

Medication Orders

	Medication	Route	Dose	Frequency	Select Treatment Type
☑	Romosozumab-aqqg (Evenity)	SQ	210 mg	Once	☐ Once monthly for _12_ dose(s) ☐ Other: _____

Order Comments: 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 105mg injections immediately one after the other

Order valid for 1 year from date of signature unless otherwise specified here:_____

Infusion Center Staff Please fax infusion records or discharge summary to:		**Fax Number**_____	
Provider Signature		**Date**	
Provider Printed Name			