

Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226



Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Evenity (romosozumab-aqqg)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose/Frequency Change <input type="checkbox"/> Order Renewal	

Location Preference (optional)	
<input type="checkbox"/> Richmond <input type="checkbox"/> Prince George	

* * If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access * *

DIAGNOSIS AND ICD-10 CODE	
<input type="checkbox"/> Osteoporosis w/o current pathological fracture	M81.0
<input type="checkbox"/> Osteoporosis with current pathological fracture*	M80.0 _____
*If <u>with</u> fracture, please provide the specific diagnosis code that is 7 digits w/ letters	
<input type="checkbox"/> Other Diagnosis: _____	ICD10 _____

REQUIRED DOCUMENTATION (must include)	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress Notes
<input type="checkbox"/> Patient Demographics AND Insurance Information	<input type="checkbox"/> Labs and Tests Supporting Primary Dx
<input type="checkbox"/> DEXA scan results and/or FRAX score	
List Tried & Failed Therapies, including duration of treatment (please comment specifically on bisphosphonates):	
1)	
2)	
3)	

MEDICATION ORDERS	
Dosing	<input type="checkbox"/> Evenity 210mg administer sub q once monthly (maximum 12 doses)
Duration:	<input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> doses _____

OPTIONAL PREMEDICATION and LAB ORDERS	
<input type="checkbox"/> Acetaminophen 650mg PO prior to Evenity administration	
<input type="checkbox"/> Diphenhydramine 25mg PO prior to Evenity administration	
<input type="checkbox"/> Methylprednisolone 40mg slow IVP	
<input type="checkbox"/> Other premed or lab order with frequency: _____	

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION			
Prescriber Name:		NPI:	Contact:
Phone:	Fax:	Email:	
Prescriber Signature:		Date:	

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com

Fax completed form and ALL required documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.