



Conveniently Located in East Syracuse, Onondaga Hill & Auburn

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Evenity (romosozumab-aqqg) Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ Height (inches): _____ Weight (lbs): _____

3. Diagnosis:

[] M80.0 (complete code) Age- related Osteoporosis with current pathologic fracture (site, encounter specific)

[] M81.0 Age-related osteoporosis without current fracture

[] Other ICD-10 Code: _____ Diagnosis description: _____

4. Pre-medications:

[] Acetaminophen: [] 1000mg PO [] 500mg PO

[] Diphenhydramine: [] 25mg PO [] 50mg PO [] 25mg IV [] 50mg IV

[] Hydrocortisone: 100mg IVP

[] Other Pre-medication: _____

[] No Pre-medications indicated

5. Drug Order:

Evenity (romosozumab-aqqg) Ok to substitute with generic/biosimilar

Dose/ Frequency:

[] 210mg monthly subcutaneously for 12 months (two separate 105mg SQ injections to upper arm, upper thigh or abdomen)

[] Other: _____

Dental Clearance:

[] Ok to proceed without dental clearance

[] Ok to proceed, dental clearance obtained, Date: _____ (copy of clearance attached)

[] New to Therapy

[] Continuing therapy: Last Dose Received _____ Next Dose Due _____

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

[] CMP within 30 days of each subsequent infusion

[] Other: _____

[] No lab monitoring indicated

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.

The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. Required Baseline Lab/Testing have been completed:

[] CMP, date: _____ [] Dexa Scan, date: _____ [] Other: _____ [] None

8. Patient Assistance & REMS Program Enrollment

[] Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)

[] No, patient has not been enrolled in any programs.

7. Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

(This drug administration order form is valid for 12 months)

Dental Clearance for Drug Administration

Patient Name: _____ **DOB:** _____

Prescribing MD: _____ **Prescribing MD Phone Number:** _____

The above mentioned patient requires therapy with the following medication, under my supervision:

_____ Zometa

_____ Xgeva

_____ Aredia

_____ Reclast

_____ Prolia

_____ Boniva

_____ Evenity

Please evaluate the patient for clearance or any other recommendations following your exam.
The patient may need follow up dental/jaw exams every six months.

Please fax this form back, with your comments, to my office at (fax) _____.

Dental Clearance APPROVED

Dental Clearance DENIED.

See Comments and Recommendation Below:

Treating Dentist: _____

Dentist Signature: _____

Date: _____