

Patient Name:

Height (inches):

Date of Birth:

Weight (lbs):

# Evenity (romosozumab-aqqg)

Non-Oncology Treatment Order Set  
Drug order form is valid for 12-months

**Please complete all fields to facilitate timely intake and prior authorization processing.**

**1. DIAGNOSIS** \*MUST match recent office visit note\*

Please include an addendum or letter of medical necessity, if appropriate.

**M80.0**  (**complete code**) - Age-related Osteoporosis w/ current pathologic fracture (site, encounter specific)

**M81.0** - Age-related osteoporosis without current fracture

Other ICD-10 Code:  Description:

**DIAGNOSIS DATE:**

**2. PRE-MEDICATION**

Acetaminophen:  1000mg PO  500mg PO

Diphenhydramine:  25mg PO  50mg PO  25mg IV  50mg IV

Hydrocortisone: 100mg IVP

Other Pre-medication:

No Pre-medications indicated

**3. DRUG ORDER**

**Evenity (romosozumab-aqqg)**

210mg monthly subcutaneously for 12 months

➤ Two separate 105mg SQ injections to upper arm, upper thigh or abdomen

Other:

**Therapy Status**

**NEW** to therapy

**Continuing** therapy-

Last dose received:  Next dose due:

Copy of Medication Administration Record is attached

**Drug-Specific Requirements** \*Fax all results to HOACNY\*

**Dental Clearance**

Please note that any invasive dental work or tooth-related pain reported to HOA of CNY staff prior to initiation or subsequent therapies may result in therapy delays until further direction of the prescribing physician.

Okay to proceed *without* dental clearance.

Okay to proceed; dental clearance has been *obtained* (attach) - Date:

Patient Name:

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### Step Therapy

Has the patient trialed & failed any of the following: Prolia, Reclast, Tymlos?  YES  NO

If YES, drug trialed:  Date range (from):  to:

### 4. REQUIRED LABS

- CMP within 30-days prior to each infusion
- None indicated

### **\*\*HOACNY 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.

### 5. LAB-INFUSION PARAMETERS

Our policy is to administer this medication as long as calcium and renal function (BUN, Creatinine and GFR) are within normal limits. If any additional monitoring parameters are required, please specify below:

### 6. COMPLETED BASELINE LABS & TESTS **\*Fax all results to HOACNY\***

- CMP
- DEXA Scan
- Other:
- None

### POLICY ACKNOWLEDGEMENT

To maintain ongoing authorization, **updated clinical documentation is required every 6-months** and a **new drug order form is required annually**. Updated documentation will be required for all dose and/or frequency changes.

**HOACNY will obtain authorization** for drug administration prior to scheduled infusion. If HOACNY is unable to obtain insurance authorization due to this medication not being in alignment with the insurance plan's medical policy, the referring office will be notified and HOACNY will not be able to administer the medication. HOACNY may use a biosimilar or generic medication based on insurance company's preferred biosimilar medications or practice preferred medications. The biosimilar medication used may change during the course of treatment depending on those preferences. HOACNY does not participate in free drug programs.

HOACNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation and management of hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. The prescribing physician is responsible for educating the patient of potential risks and complications associated with the drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Medication Infusion Services referral. The prescribing provider is responsible for identifying and managing any side effects of the prescribed medication and for determining whether it is appropriate to proceed with treatment. Please call our office to coordinate with our Infusion Services Nurse Navigator, as appropriate. Any changes in condition or delayed adverse events that occur after leaving the infusion center will be reported to the prescribing physician for evaluation & management.

Provider's Name:

Phone:

Provider's Signature:

Date:

## Dental Clearance for Drug Administration

Patient Name:

Date of Birth:

Prescribing Physician:

Prescribing Physician's Phone #:

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

- |                                  |                                  |
|----------------------------------|----------------------------------|
| <input type="checkbox"/> Zometa  | <input type="checkbox"/> Prolia  |
| <input type="checkbox"/> Xgeva   | <input type="checkbox"/> Boniva  |
| <input type="checkbox"/> Aredia  | <input type="checkbox"/> Evenity |
| <input type="checkbox"/> Reclast |                                  |

*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**

Comments & Recommendations:

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Treating Dentist:

Date:

Dentist Signature: