Fax: 832-895-4040
Phone: 832-895-5000
E-mail: intake@adaptivinfusion.com

adaptIV infusion

Evenity (romosozumab-aqqg)

Provider Order Form rev. 10/19/2022

PATIENT INFORMATION

Referral Status *(check one)*: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: ____________________ DOB: __________

NKDA ☐ Allergies: ____________________ Weight ______ *Please specify:* ☐ lbs ☐ kg Height: ______

Patient Status *(check one)*: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: __________ Next Due Date: __________

ICD-10 code (required): __________ ICD-10 description: ____________________

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

CLINICAL INFORMATION

☐ Therapies Tried and Failed: ____________________

☐ TB Test: Date: ______ Results: __________

☐ Hep B Test: Date: ______ Results: __________

☐ Is patient currently taking Calcium/Vitamin D supplement? ☐ Yes ☐ No
Date of last Calcium/Vitamin D: __________

☐ Does patient have history of fractures? ☐ Yes ☐ No

☐ Date of last DEXA scan: __________

☐ Clinical note for last DEXA scan attached? ☐ Yes ☐ No

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV

☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: ____________________

Dose: __________ Route: __________

Frequency: ____________________

THERAPY ADMINISTRATION

☐ **Evenity**

☐ Dose: 210mg (two 105mg injections)

☐ Frequency: every month for 12 months

STANDING ORDERS FOR ADVERSE REACTIONS

☐ Stop infusion and initiate NS bolus

☐ Notify supervising physician and ordering provider

☐ Solu-Cortef 100mg SIVP signs of adverse reaction

☐ Benadryl 25mg SIVP for hives or bronchial inflammation

☐ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis

☐ Oxygen 2-5L nasal cannula

☐ Albuterol 2.5mg inhaled PRN for chest tightness

☐ Other: ____________________

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: ____________________ Referral Coordinator Email: ____________________

Ordering Provider: ____________________ Provider NPI: ____________________

Referring Practice Name: ____________________ Phone: __________ Fax: __________

Practice Address: ____________________ City: __________ State: ______ Zip Code: ______

Provider Name (Print) ____________________ *Provider Signature* ____________________ *Date* __________

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK