

(Romosozumab)

Evenity injection order



Patient Name _____

DOB _____

Phone Number _____

M ____ F ____

DIAGNOSIS *Please provide ICD-10 code*

_____ Osteoporosis

_____ Other

PRE-MEDICATIONS (optional)

Acetaminophen 1000mg PO

Diphenhydramine 25mg PO

Cetirizine 10mg PO

_____ (other)

Solu-Medrol 125mg IVP

Solu-Cortef 100mg IVP

Diphenhydramine 25mg IVP

_____ (other)

Evenity (Romosozumab) ORDERS

DOSAGE & FREQUENCY

210mg SQ once every 4 weeks for 12 months

_____ Other

Patient Weight

_____ lbs

_____ kg

NOTES:

ORDERING PROVIDER

Signature _____ Phone _____ Fax _____

Provider _____ Date _____