Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Evenity® (romosozumab-aqqg) Injection Order (Revised 10/14/2025)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list)		
☐ NKDA		

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

- ☐ M80.0.____ Age-related Osteoporosis with curren pathological fractiure
- ☐ M81.0 - Age-related Osteoporosis without current fractures
- ☐ Other:

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:

- ☑ Required Lab Results: Calcium within 3 months prior to treatment and 1 week PRIOR to second treatment. Creatine within 3 months of each treatment. (**Fax labs with order**)
- ☑ Notify Provider IF: Lab results are not available; Calcium: Abnormal lab value; Creatin Clearance LESS THAN 30mL/min.

Nursing Communication:

- ☑ Obtain vital signs PRE-injection and POST-injection.
- ☑ Assess for recent implants, root canals, or invasive dental work. Notify provider if patient has had recent invasive dental work.
- ☑ Confirm that patient has not had a stroke or cardiac event in the past year.
- ☑ Monitor patient for signs of reaction for 30mins after completion of 1st injection and subsequent injections PRN if previous signs of reaction observed.

Infusion Therapy:

- ☑ Evenity (romosozumab-aqqg) 210mg every 4 weeks x 12 doses

Supportive Care Medications:

- ☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.
- ☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.
- ☑ Ondansetron (Zofran) tablet 4mg PO ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

- ☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:

Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: