



Trinity Health Muskegon & Shelby Infusion Clinics

Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444

Shelby: 72 S. State St. Shelby, MI 49455

Fax (shared): 231-672-3970

Romozozumab-aqgg (Evenity®)

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ___/___/___ Site of Service: TH Muskegon TH Shelby

Referral Status: New Referral Dose or Frequency Change Renewal

Patient Name: _____ Date of Birth: ___/___/___ Weight: ___kg Height: ___cm Allergies: _____	Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____
<p align="center">Diagnosis</p> Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____	<p align="center">Labs (every 30 days prior to treatment)</p> <input type="checkbox"/> Albumin <input type="checkbox"/> Calcium <input type="checkbox"/> Creatinine, serum <input type="checkbox"/> Other: _____
NOTE TO PROVIDER: All patients with Romozozumab-aqgg (Evenity®) prescribed should receive 500-1000 mg Calcium and 600-800 IU Vitamin D daily per prescribing information (note: Calcium is best absorbed if doses greater than 500 mg are divided).	
Hold and notify physician if: Patient has severe hypocalcemia (albumin-adjusted calcium below 7 mg/dL). Calcium level should be corrected prior to initiation of treatment.	
Pre-medications: No routine pre-medications are given. Pre-medications may be ordered at physician discretion. <input type="checkbox"/> Other: _____	
<p>Rx Romozozumab-aqgg (Evenity®) 210 mg via subcutaneous injection every 30 days</p> <p>Note to Nurse: Two separate syringes (two separate subcutaneous injections) are needed to administer the total dose of 210 mg. Inject in the abdomen, thigh, or upper arm.</p> <p>Nursing Orders: Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary: sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN.</p>	
Provider Name: _____ Office Phone Number: _____ Attending Physician Name: _____ <i>(If ordering provider is an advanced practice practitioner)</i> <i>Note: This order is valid for 12 months from date of physician signature.</i>	Provider Signature: _____ Office Fax Number: _____