



Thank you for selecting our infusion services team to care for your patient. Please provide ALL information listed below to ensure that we can process orders and schedule your patient for treatment without delay.

Part A- Patient scheduling and contact information:

Patient Name (Last, First): _____ Date of Birth: _____

Patient Contact Information and Phone Number(s): _____

Ordering Provider Name (Print): _____

Provider Clinic or Service Address: _____

Clinic or Service Phone Number: _____ Clinic or Service Fax Number: _____

Diagnosis (include ICD 10 codes): _____

Medication and Service Requested - list J-Code/CPT code if known: _____

Date Service is Requested to Begin: _____ **Date Service is Expected to End:** _____

Order will expire 1 year from date of provider signature unless "date service is expected to end" is earlier.

Part B- Insurance and Prior Authorization. Any non-PeaceHealth provider must obtain prior authorization prior to service. Attach a copy of authorization documentation received from insurance payer when submitting orders.

Insurance (Payer) Company: _____

Prior Authorization Number and Conditions: _____

Prior Authorization Expiration Date: _____

Insurance (Payer) Contact Phone Number: _____

Part C- Elements needed to guide medication therapy are included with request for service:

- ☐ Orders and instruction (use the PeaceHealth approved ordering form if you are not a PeaceHealth provider) are complete and include provider signature at the bottom of each page. Check the boxes of ALL orders you would like to activate.
- ☐ For blood products, PeaceHealth Blood and Transfusion Consent form is signed and dated by the provider and the patient.

If information is located outside of PeaceHealth's electronic medical record system attach the following:

- ☐ A list of current medications reconciled by patient provider is available and includes a list of known allergies.
- ☐ Recent progress notes from ordering provider.
- ☐ A copy of relevant laboratory results and other appropriate supporting documentation.

IMPORTANT MESSAGE TO PROVIDERS: To reduce delays in treatment and added phone calls, you may participate to utilize PeaceHealth preferred medication formulary options by signing this document. A clinical pharmacist will adjust orders to align with PeaceHealth medical staff approved medication formulary options, policies, and procedures.

I agree to utilize PeaceHealth preferred medication formulary options, policies and procedures that have been authorized by PeaceHealth Medical Staff. This agreement will be issued for the duration of active orders contained within this treatment plan.

PROVIDER SIGNATURE: _____ **DATE:** _____ **TIME:** _____

FAX completed service request and orders to: PHMC OP Infusion and Nursing Services 541-902-1649



Romosozumab-aqqg (Evenity) Outpatient Infusion Therapy Plan

All Pre-Selected Boxed Orders Are Initiated by Default Unless Crossed Out by Practitioner. All Boxed Orders Require Practitioner Check to be Initiated.

Heading	Content
For Admission to Service	Provider Instruction – Please review information below and address requirements for admission to service: - Romosozumab administration is restricted to the following: - Diagnosis of osteoporosis in a postmenopausal female considered to be a high fracture risk - Bone mass T score of less than -3 - Bone mass T score of less than -2.5 with fragility fracture history - Severe or multiple prior vertebral fractures - May be considered for use as an alternative agent if no other first line agent is tolerated or effective - Continuation of therapy - Romosozumab may increase the risk of myocardial infarction, stroke, and cardiovascular death. Do not initiate treatment in patients who have had a myocardial infarction or stroke within the preceding year. Consider whether the benefits outweigh the risks in patients with other cardiovascular risk factors. If a patient experiences a myocardial infarction or stroke during therapy, romosozumab should be discontinued. - Correct hypocalcemia and vitamin D deficiency (e.g., to a 25-hydroxyvitamin D level ≥ 20 ng/mL [≥ 50 nmol/L]) prior to initiating therapy and ensure adequate calcium and vitamin D intake during therapy. 1000 – 1200 mg of calcium and 800 – 1000 units of vitamin D daily are generally suggested (total of diet and supplement). - There is risk for osteonecrosis of the jaw while on romosozumab. Remind patient of the importance of good dental hygiene, ensure patient has had a satisfactory dental exam prior to start of therapy and consider risks/benefits of invasive dental procedures during treatment. - Limit duration of use to 12 monthly doses. If osteoporosis therapy remains warranted, continued therapy with an anti-resorptive agent should be considered. - Review medication information and provide patient with a written copy of the FDA-approved patient medication guide for Romosozumab.
Supportive Care	☒ Romosozumab-aqqg (Evenity) 210 mg subcutaneously every 28 days for 12 doses
Nursing Orders	☒ Nursing communication – Remind patient of good dental hygiene and to avoid invasive dental procedures. ☒ Nursing communication – Draw CMP at baseline, wait for lab result. If corrected calcium is less than 8.5, hold treatment and contact provider. Draw CMP at month 6 and 12 of treatment. Do not wait for lab result to proceed with treatment. If calcium is less than 8.5, contact provider for instruction.
Labs	☒ CMP at baseline, month 6 of treatment, and at month 12 of treatment ☒ Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post this planned treatment date.

Practitioner Signature: _____ **Date of Order:** _____ **Time:** _____

Final page of orders must include signature of the ordering practitioner, date, and time.



Romosozumab-aqqg (Evenity) Outpatient Infusion Therapy Plan

All Pre-Selected Boxed Orders Are Initiated by Default Unless Crossed Out by Practitioner. All Boxed Orders Require Practitioner Check to be Initiated.

Heading	Content
Emergency Medications	If patient has symptoms of anaphylaxis (wheezing, dyspnea, hypotension, angioedema, chest pain, or tongue swelling), discontinue infusion and initiate standard emergency response procedures. ☒ DiphenhydrAMINE (Benadryl) injection 25-50 mg IM once as needed for mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (≥ 20 points in SBP), nausea, urticaria, chills, pruritis). - Administer 50 mg IM if patient has NOT had diphenhydramine within 2 hours of reaction - Administer 25 mg IM if patient has had diphenhydramine within 2 hours of reaction, if reaction doesn't resolve in 3 minutes may repeat 25 mg IM dose for a total of 50 mg and notify provider. ☐ Albuterol 90 mcg/actuation inhaler 2 puffs once as needed for wheezing, shortness of breath associated with infusion reaction and contact provider. Administer with a spacer if available. ☒ MethylPREDNISolone (Solu-Medrol) injection 125 mg IM once as needed for shortness of breath for continued symptoms of mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (≥ 20 points in SBP), nausea, urticaria, chills, pruritis) that worsen or persist 5 minutes after administration of diphenhydramine (Benadryl), and notify provider. Do not inject into deltoid. ☒ EPINEPHrine (Adrenalin) injection 0.5 mg IM once as needed for severe drug reaction (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort plus blood pressure changes (≥ 40 points in SBP), shortness of breath with wheezing and O2 Sat less than 90%), and notify provider.
Referral	☒ Ambulatory referral to OP Infusion Services
PHMC Outpatient Infusion Contact Information	PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO: PeaceHealth Peace Harbor Medical Center Outpatient Infusion Services Department 400 Ninth Street Florence, OR 97439 Contact Phone: 541-902-6019 and FAX 541-902-1649
Authorization by Verbal or Telephone Order	Person giving verbal or telephone order: _____ Person receiving verbal or telephone order: _____ ☐ Check to indicate verbal or telephone orders have been read back to confirm accuracy

Practitioner Signature: _____ **Date of Order:** _____ **Time:** _____

Final page of orders must include signature of the ordering practitioner, date, and time.