Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: ______________________________ Patient D.O.B.__________________________

Current Height: ___________________________ Current Weight___________________________

Patient Phone # (______) _______-________________ Gender________________________

Patient Address ____

City_________________ State _______________ Zip Code__________________________

Related Diagnosis Code (ICD-10 code): ____

Referring Provider (Please Print) ____

Office Phone # (______) _______-________________ Office Contact: _____________________________

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Evenity® (romosozumab-aqqg) Treatment Plan

Patient Name: ________________________________ **Patient DOB** __________________________

General

☐ Diagnosis- Osteoporosis ICD-10:_________________

Pt. Weight _____________ Pt Height _____________ Known Allergies _____________

Requested Start Date ____/____/_______

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last injection ____/____/_______

Authorized Treatment Duration

☐ 12 months ☐ Other__________________

Injection (Month 1 to 12) (Evenity should NOT be initiated in patients with a history of MI or stroke within the past year)

☑ Vital Signs (Month 1 to 12)
Resp, BP, HR, Temperature prior to injection and prior to discharge

☑ **Evenity (romosozumab-aqqg) (Month 1 to 12)**
210 mg, Subcutaneous, Injection, Day of Tx
Comments: Total dose to be given as two separate 105 mg injections administered immediately one after the other, into the abdomen, thigh, or outer area of upper arm.

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, Pruritis, urticaria, persistent flushing, Temperature > 100 or HR <50 or > 130

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

☑ Communication Order (Month 1 to 12)
Nursing to verify with patient that no invasive dental procedures are planned or have been recently performed. If patient answers yes, nursing to contact provider prior to proceeding with injection.

☑ Communication Order (Month 1 to 12)
Nursing to monitor patient for 15 minutes after injection

☑ Communication Order (Month 1 to 12)
Nursing to verify patient has vitamin D level within the last 12 months prior to treatment initiation and within 6 months of subsequent injections. Nursing to notify provider if vitamin D level less than 25 ng/ml.

☑ Communication Order (Month 1 to 12)
Nursing to verify patient has calcium level within the last 45 days prior to treatment initiation and within 6 months of subsequent injections. Nursing to notify provider if calcium level returns less than 8.8mg/dL.

Labs (Month 1 to 12) Duration: 12 Months

☑ Calcium Level (if needed)

☑ Vitamin D level (if needed)

Attestation

Required Patient Counseling: Ordering provider has counseled patient on associated risks of medication including but not limited to osteonecrosis of the jaw, importance of regular dental exams, good oral hygiene, appropriate intake and/or supplementation of Vitamin D / Calcium and supplied patient with appropriate medication guide.

Provider initials_____________ (required)

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature ________________________ Provider Name (please print)________________________

Date_____/_____/_________ Patient Name ___________________________ Patient DOB______________