Evenity Injection Order
(Romosozumab-aqqg)

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

*Please fax a copy of the following patient information:
❒ Demographics ❒ Insurance Information ❒ Current Medications
❒ H & P Relevant to Diagnosis ❒ Recent Office Notes
❒ Current CBC & CMP (calcium within 30 days)

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

EVENITY (ROMOSOZUMAB-AQQG) DOSAGE:

Date of Last Treatment, If Continuation:

200 mg subcutaneous (2 x 105 mg)
once a month for 12 months

Labs drawn on: _____

Serum Calcium: _____ Serum Calcium: _____

*** See package insert regarding serum calcium monitoring.**