PINNACLE NEUROLOGY & INFUSION

Evenity (romosozumab-aqqg) Injection Orders

Patient Name:_____ DOB:_____

Allergies:_____ Height:_____ Weight:_____

Male:_____ Female:_____

ICD-10 Diagnosis code:_____

Pre-Medication: *(if requested)*

_____ Tylenol 1000mg PO

_____ Diphenhydramine 25 mg PO

_____ Cetrizine 10mg PO

Evenity Order:

_____ mg to be administered every _____ weeks for _____ months

Prescriber signature:_____

Date:_____