Evenity/Prolia/Reclast/Boniva

Provider Order Form rev. 8/12/2025

IVCARE INFUSION
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Phone : (615) 471-8673
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PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB: Phone:

ICD-10 code (Required): ICD-10 Description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

0 TB status & date (list results here & attach clinicals)

_____

☑ Provide nursing care per IVCare Infusion's Nursing Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

☐ Serum Calcium ☐ before each dose ☐ every _____

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

Medication

☐ **Evenity (Romosozumab)**
- ☑ Dose: 210 mg (two 105 mg syringes) Subcutaneously
- ☑ Frequency: Inject 210 mg once every month for 1 year

☐ **Prolia (Denosumab)**
- ☑ Dose: 60 mg Subcutaneously
- ☑ Frequency: Inject every 6 months for a total 2 doses per year

☐ **Reclast (Zoledronic acid)**
- ☑ Dose: 5 mg/100ml Intravenously no less than 30 mins infusion
- ☑ Frequency: ☐ Every 12 months x 1 year (Treatment Dose)
  ☐ Every 24 months (Preventative Dose)

☐ **Boniva (Ibandronate sodium)**
- ☑ Dose: 3 mg / 3 ml PFS Intravenously over a period of 15 to 30 seconds.
- ☑ Frequency: Inject every 3 months for 1 year

(If not indicated, order will expire one year from date signed)

Is the patient currently taking Calcium and Vitamin D? Yes No, reason for not taking: _____

Serum calcium is required within 3 months of appointment.

Result Date: _____ Lab Result: _____

SPECIAL INSTRUCTIONS

_____

Provider Name (Print) **Provider Signature** **Date**

Email info@ivcareinfusion.com or Fax this Form, Insurance card (both sides), Demographics, Recent H&P, Labs & supporting Clinicals to:

FAX NUMBER FOR REFERRALS: (615) 471-8674