Care Fusion INFUSION CENTERS

AIC Endocrinology #1

Fax:855-733-9898
Phone: 877-460-3905

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

Medical Assessment

Diagnosis:

- ❑ M80.0__ Age related Osteoporosis with current fracture
- ❑ M81.0 Age related Osteoporosis without current fracture
- ❑ C61 Malignant Neoplasm of the Prostate
- ❑ C50.__ Breast Cancer
- ❑ Other: _____

Failed Medications: _____

Has the patient tried and failed oral bisphosphonates? If so, which ones and when? _____

Dexa Scan T Score: _____ Type: _____ Date: _____

Fracture History: Site _____ Date: _____

Thyrogen Use: (Please mark)

- ❑ Use as an adjunctive treatment as pre-therapeutic stimulation for radioiodine ablation of thyroid tissue remnants in patients maintained on thyroid hormone suppression therapy who have undergone a near-total or total thyroidectomy for well-differentiated thyroid cancer without evidence of distant metastatic thyroid cancer.
- ❑ Use as an adjunctive diagnostic tool for serum thyroglobulin (Tg) testing, with or without radioiodine imaging, in the follow-up of patients with well-differentiated thyroid cancer
- ❑ Other: _____

Pre-Medication Orders:

- ❑ APAP □ 325mg □ 500mg □ 650mg - PO 30 minutes before infusion
- ❑ Diphenhydramine □ 25mg □ 50mg – PO 30 minutes before infusion OR □ 25mg IVP □ 50mg IVP
- ❑ Alternate Oral Antihistamines: □ Cetirizine 10mg □ Loratadine 10mg □ Fexofenadine 60mg or □180mg
- ❑ Methylprednisolone □ 40mg IVP □ 125mg IVP or other _____ mg IVP
- ❑ Famotidine □ 20mg PO □ 40mg PO □ 20mg IVP □ 40mg IVP
- ❑ Ondansetron □ 4 mg IVP □ 4 mg PO

Labwork: _____ To be Drawn by: □ Infusion Clinic □ Referring Provider

Allergies: _____

Medication

Thyrogen (thyrotropin alpha)

Dosage / Frequency:

- ❑ Thyrogen 0.9mg IM on day 1 and 2.

Evenity (romosozumab-aqqg)

Dosage / Frequency:

- ❑ Evenity 210mg SQ monthly for 12 months. **Maintenance Refills**: ___

Ibandronate Sodium (generic Boniva)

Dosage / Frequency:

- ❑ Ibandronate sodium 3 mg IV every 3 months. **Maintenance Refills**: ___

Physician Prescription Orders

Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

NPI #_____ Physician Signature: _____ ***Date:*** _____