Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Specialty Order Form

Patient:_____	Ordering Provider:_____
DOB:_____ ☐ M ☐ F	NPI:_____
Height:_____ Weight:_____ lbs.	Practice:_____
Allergies:_____	Phone:_____
Diagnosis:_____	Fax:_____
ICD-10 Code(s):_____	Contact Name:_____

Has the patient been treated for this condition previously? ☐ No ☐ Yes, medication(s):_____

Is the patient currently on therapy? ☐ No ☐ Yes, medication(s):_____

☐ **EVENITY (ROMOSOZUMAB-AQQG)** 210 mg Evenity by SubQ injection every month for 12 months.

☐ **PROLIA (DENOSUMAB)** 60 mg Prolia by SubQ injection every 6 months.

☐ **RECLAST (ZOLEDRONIC ACID)** 5 mg Reclast IV every 1 year. (OSI will need a new order for each dose given).

Quick Checklist

☐ Demographic sheet and copy of insurance card(s).

☐ Completed Oregon Specialty Infusion Order Form

☐ Signed RX

☐ Recent Progress Note

☐ Recent CMP

☐ DEXA scan within the last 2 years

Physician's Signature:_____ **Date:**_____

Fax completed form to **(503) 540-3105**

Questions? Call us at **(503) 540-9999**