Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER
Romosozumab-aqqg (EVENITY) Injection

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: ____________kg **Height:** ____________cm

Allergies: ____

Diagnosis Code: ____

Treatment Start Date: ______________ **Patient to follow up with provider on date:** ____________________

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Romosozumab may increase the risk of MI, stroke, and cardiovascular death. It should not be initiated in patients who have had a myocardial infarction or stroke within the preceding year. Consider whether the benefits outweigh the risks in patients with other cardiovascular risk factors.
3. Duration of therapy is limited to 12 monthly doses.
4. Confirm patient has had recent oral/dental evaluation if indicated prior to initiating therapy.
5. Hypocalcemia must be corrected prior to initiation of therapy. All patients should be prescribed daily calcium and Vitamin D supplementation.
6. Risk versus benefit regarding osteonecrosis of the jaw and hip fracture must be discussed prior to treatment.
7. A complete metabolic panel is recommended and a calcium level must be obtained within 30 days prior to starting treatment.
8. **Must complete and check the following box:**
   - ☐ Provider confirms that the patient has had a recent oral or dental evaluation and/or has no contraindications to therapy related to dental issues prior to initiating therapy.

LABS:

☑ Complete Metabolic Panel, Routine, ONCE, every 4 weeks.

NURSING ORDERS:

1. TREATMENT PARAMETER #1 – Pharmacist to calculate Corrected Calcium. Hold and contact provider for Corrected Calcium less than 8.4 mg/dL.
2. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.
3. Please remind patient to take at least 500 mg elemental calcium twice daily and 400 IU Vitamin D daily.
4. RN to assess for previous myocardial infarction (MI) or stroke at every visit. Hold and contact provider if patient had a MI or stroke. Romosozumab-aqqg may increase the risk of MI, stroke, and cardiovascular death. If a patient experiences a MI or stroke during therapy, romosozumab-aqqg should be discontinued.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

☑ Romosozumab-aqqg (EVENITY) 210 mg injection, subcutaneous, ONCE, every 4 weeks for 12 doses

Allow syringes to sit at room temperature for at least 30 minutes before use. Inject two 105 mg/1.17 mL syringes for a total dose of 210 mg. Administer into the thigh, abdomen (except for a 2 inch area around the navel), or outer area of upper arm. Rotate injection sites.

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ ________________ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _________________ <u>(MUST BE COMPLETED TO BE A VALID PRESCRIPTION)</u>; and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: ______________________________ **Date/Time:** ______________________

Printed Name:_____________________________ **Phone:** ________________ **Fax**:_____________

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Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756