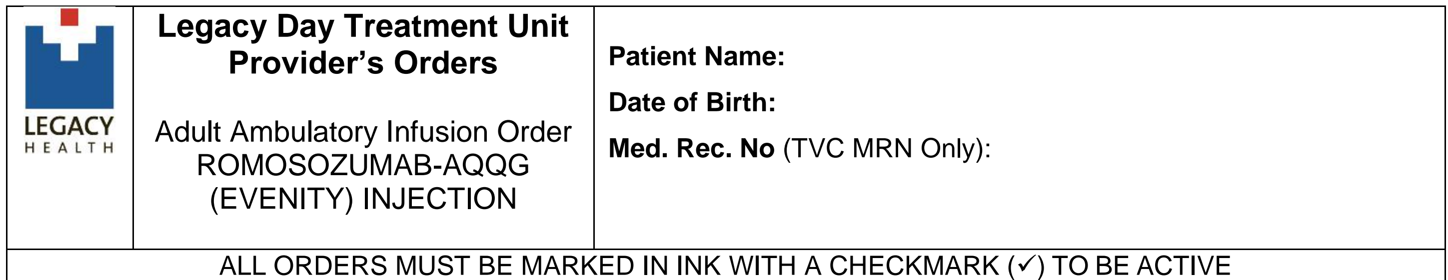


LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order ROMOSOZUMAB-AQQG (EVENITY) INJECTION	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):

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

Anticipated Start Date: ___________ **Patient to follow up with provider on date:** ___________
*****This plan will expire after 365 days, unless otherwise specified below*****
Orders expire: ______________________

Weight: ___________kg **Height:** ___________cm

Allergies: ____

Diagnosis: ___________________

Diagnosis Code: ________________________ (**please include primary and secondary diagnosis codes)**

GUIDELINES FOR PRESCRIBING:

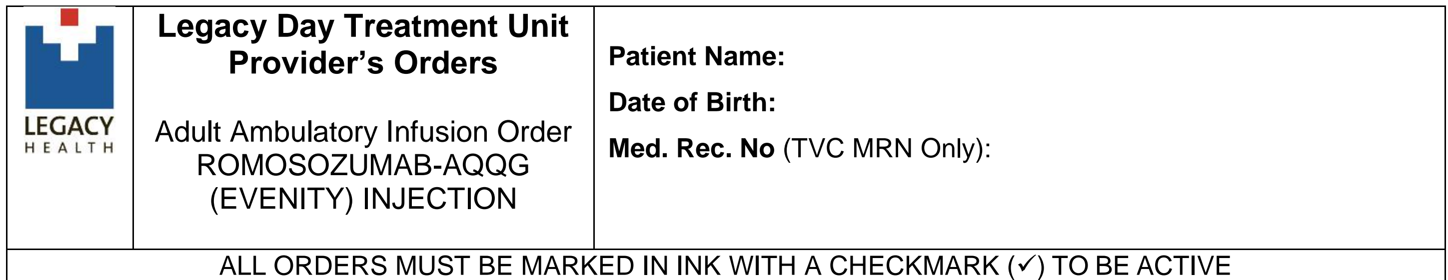
1. Send **FACE SHEET and H&P or most recent chart note.**
2. Romosozumab may increase the risk of MI, stroke, and cardiovascular death. It should not be initiated in patients who have had a myocardial infarction or stroke within the preceding year. Consider whether the benefits outweigh the risks in 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 TO BE DRAWN (orders must be placed in TVC Epic by ordering provider if TVC provider):

☑ Complete Metabolic Panel, Routine, ONCE, every visit

NURSING ORDERS (TREATMENT PARAMETERS):

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.



	Legacy Day Treatment Unit Provider's Orders Adult Ambulatory Infusion Order ROMOSOZUMAB-AQQG (EVENITY) INJECTION	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):

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

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. Refer to LH policy 906.6606 Initiation of Emergency Measures for Adult Oncology, Radiation Oncology and Infusion Clinic Patients
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. Avoid use of steroids unless directed by provider. Steroids may compromise effectiveness of drug.
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
6. albuterol (PROVENTIL HFA) inhaler, 4 puff, inhalation, EVERY 4 HOURS PRN, wheezing
7. 0.9% NaCl, 500 mL, intravenous, CONTINUOUS PRN over 2.5 hours, for hypersensitivity or infusion reaction

<table>
<tr><td> </td><td>Legacy Day Treatment Unit
Provider's Orders

Adult Ambulatory Infusion Order
ROMOSOZUMAB-AQQG
(EVENITY) INJECTION</td><td>Patient Name:
Date of Birth:
Med. Rec. No (TVC MRN Only):</td></tr>
<tr><td colspan="3">ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE</td></tr>
</table>

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

☐ **Legacy Day Treatment Unit –**
The Vancouver Clinic Building
A department of Salmon Creek Medical Center
700 NE 87th Avenue, Suite 360
Vancouver, WA 98664
Phone number: 360-896-7070
Fax number: 360-487-5773

☐ **Legacy Salmon Creek Day Treatment Unit**
Legacy Salmon Creek Medical Center
2121 NE 139th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773

☐ **Legacy Woodburn STEPS Clinic**
A department of Silverton Medical Center
Legacy Woodburn Health Center
1475 Mt Hood Ave
Woodburn, OR 97071
Phone number: 503-982-1280
Fax number: 503-225-8723

☐ **Legacy Emanuel Day Treatment Unit**
A department of Emanuel Medical Center
501 N Graham Street, Suite 540
Portland, OR 97227
Phone number: 503-413-4608
Fax number: 503-413-4887

☐ **Legacy Silverton STEPS Clinic**
Legacy Silverton Medical Center
342 Fairview Street
Silverton, OR 97381
Phone number: 503-873-1670
Fax number: 503-874-2483

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

Printed Name: ___________________________ **Phone:** _______________ **Fax:** _____________

Organization/Department: ____