



**St. Charles Health System**

Adult Ambulatory Infusion Order  
Romosozumab-aqqg (EVENTY)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

*Patient Identification*

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

**Treatment Start Date:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

**Weight:** \_\_\_\_\_ **kg** **Height:** \_\_\_\_\_ **cm**

**REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety**

- 1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
- 2. Recent VISIT NOTE to support treatment (if not available in Epic)**
- 3. LAB RESULTS for any required prescreening (if not available in Epic)**
- 4. DIAGNOSIS CODE** \_\_\_\_\_
- 5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

**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 8.6 mg/dL (or ionized calcium less than or equal to 1.1 mmol/L).
2. TREATMENT PARAMETER #2 – Verify vitamin D level has been drawn within the last 12 months, hold injection and contact provider for vitamin D level less than 27.
3. TREATMENT PARAMETER #3 – Verify creatinine level has been drawn within the last 12 months, hold injection and contact provider for BSA-adjusted eGFR less than 40 mL/min.



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4. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.
5. 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.
6. Vital signs before injection then PRN
7. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declothing (alteplase), and/or dressing changes.

**MEDICATIONS:**

Romosozumab-aqqg (EVENTY) 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.

**INFUSION MONITORING/REACTION:**

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center  
2500 NE Neff Road, Bend, OR 97701  
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form



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**ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION**

Signature: \_\_\_\_\_ License #: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Plan will expire 1 year after signature date at which time a new order will need to be placed**