Columbus Community Hospital
Columbus, Nebraska
DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here ☐

PHYSICIANS ORDERS
(including Medications)

Romosozumab-aqqg (EVENITY) Injection (8/2024) Page 1 of 2

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. 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:

☑ Serum Calcium, Routine, ONCE, every 4 weeks.

NURSING ORDERS:

1. Monitor Serum Calcium. Hold and Contact provider if less than 8.6 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 weeksfor 12 doses

  Allow syringes to sit at room temperature for at least 30 minutes before use. Inject two 105 mg/1.17 mL

(cont.)

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PHYSICIANS ORDERS
(including Medications)

Romosozumab-aqqg (EVENITY) Injection

HYPERSENSITIVITY:

1. NURSING COMMUNICATION – If hypersensitivity reactions develop, refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Continue to assess as grade of severity may progress.
5. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:

- **Acetaminophen**, **975 mg**, PO, x 1 dose, AS NEEDED for hypersensitivity or infusion reaction.
- **DiphenhydrAMINE inj, 50 mg**, IV, AS NEEDED for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
- **Hydrocortisone Sodium Succinate, 100 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Famotidine, 20 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
- **0.9% Normal Saline, 1000 mL**, IV, 150mL/hr, AS NEEDED for hypersensitivity or infusion reaction.
- **EPINEPHrine HCl (1mg/1mL), 0.3 mg**, IM injection, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.

My NPI number is _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); 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:** _____