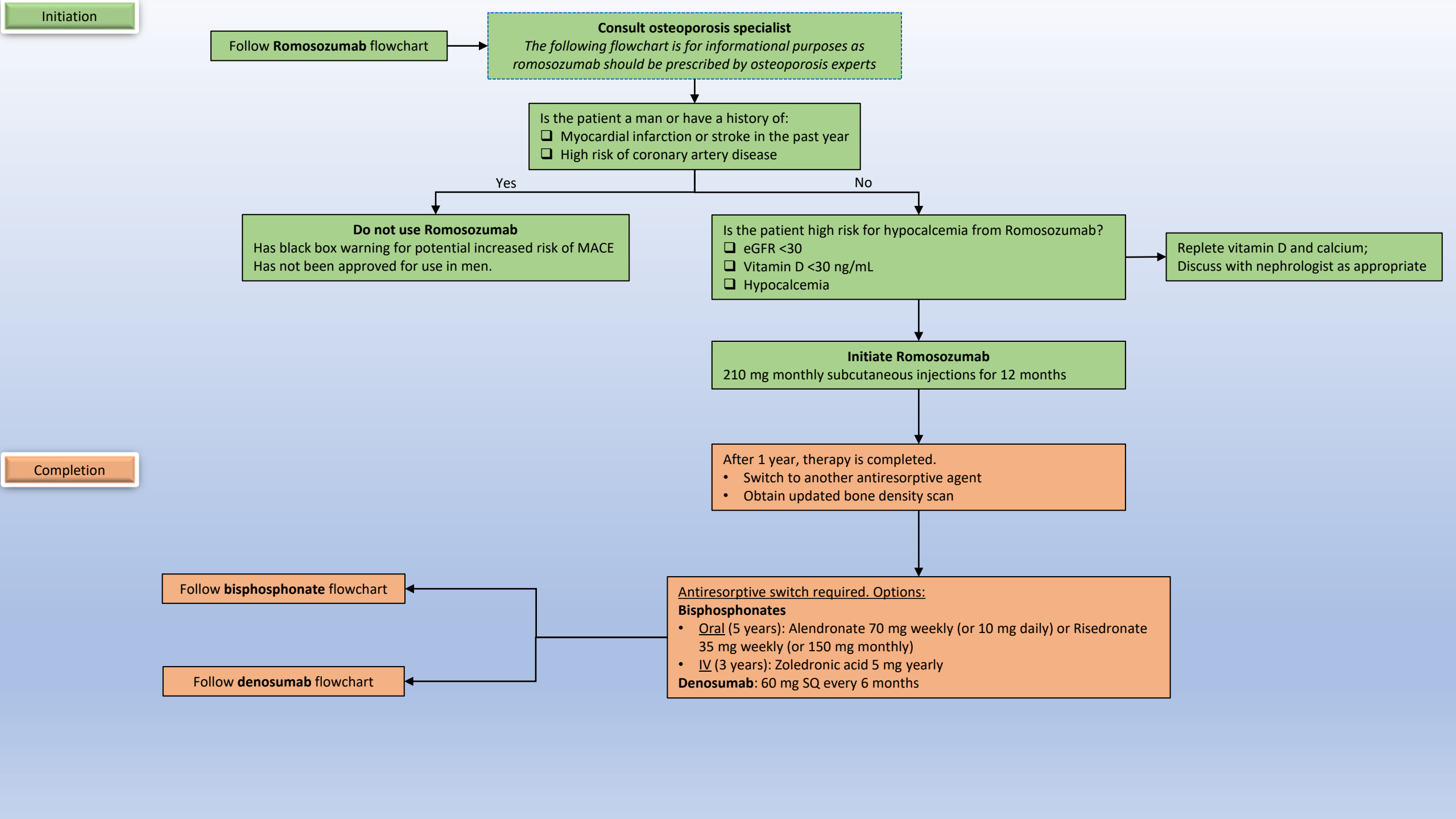
Initiation
Follow **Romosozumab** flowchart
Consult osteoporosis specialist
The following flowchart is for informational purposes as romosozumab should be prescribed by osteoporosis experts
Is the patient a man or have a history of:
❑ Myocardial infarction or stroke in the past year
❑ High risk of coronary artery disease
Yes
No
Do not use Romosozumab
Has black box warning for potential increased risk of MACE
Has not been approved for use in men.
Is the patient high risk for hypocalcemia from Romosozumab?
❑ eGFR <30
❑ Vitamin D <30 ng/mL
❑ Hypocalcemia
Replete vitamin D and calcium;
Discuss with nephrologist as appropriate
Initiate Romosozumab
210 mg monthly subcutaneous injections for 12 months
Completion
After 1 year, therapy is completed.
• Switch to another antiresorptive agent
• Obtain updated bone density scan
Antiresorptive switch required. Options:
Bisphosphonates
• Oral (5 years): Alendronate 70 mg weekly (or 10 mg daily) or Risedronate 35 mg weekly (or 150 mg monthly)
• IV (3 years): Zoledronic acid 5 mg yearly
Denosumab: 60 mg SQ every 6 months
Follow **bisphosphonate** flowchart
Follow **denosumab** flowchart

Consult osteoporosis specialist

The following flowchart is for informational purposes as romosozumab should be prescribed by osteoporosis experts

Romosozumab is a sclerostin inhibitor. (JCEM 2020 Guidelines – Romosozumab update, Romosozumab package insert)

Romosozumab is the most novel medication for osteoporosis gaining FDA approval in 2019 and being incorporating in JCEM guidelines in 2020.

- It should be considered as a first line agent for patients with multiple vertebral fractures or hip fracture and an osteoporotic BMD or for those who failed antiresorptive medications
- The medication is extremely potent
    - Example: 73% reduction in risk of vertebral fractures after 1 year!

In clinical trials there was an increased risk of major adverse cardiovascular events in romosozumab compared to the alendronate treated group.

- Led to a black box warning that there may be an increased risk of myocardial infarction, stroke, or cardiovascular death and that it should not be used in patients who had a myocardial infarction or stroke in the past year.
- More studies are needed if this is due to a romosozumab effect or protective alendronate effect

Because Romosozumab is novel and expensive, the medication should be prescribed by an osteoporosis expert. Those who are not experts should still be aware of its use and potential to consider consultation.

- It is administered by a healthcare provider in two separate syringes totaling 210 mg once per month to the abdomen, thigh, or upper arm once monthly for 12 months.

Romososumab should be switched after 1 year of therapy to an alternative antiresorptive agent such as bisphosphonates or denosumab. If those cannot be tolerated raloxifene or menopausal hormone therapy is acceptable