



ADULT AMBULATORY INFUSION ORDER
PORECLA-06/21
Zoledronic Acid (RECLAST) Infusion

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

Weight: _____ kg Height: _____ cm Allergies: _____
Diagnosis Code: _____
Treatment Start Date: _____

****These orders will expire after 365 days; new orders are needed after the expiration date****

GUIDELINES FOR ORDERING:

- Send FACE SHEET and H&P or most recent chart note.
- If labs are not accessible through Epic, please fax a copy of patient lab work as well (see below).
- This order should be used in patients with Paget’s disease or osteoporosis. Do not use this order if a patient is already being treated with Zoledronic acid (ZOMETA).
- Please confirm that the patient has had a recent dental evaluation prior to initiating therapy.
- Hypocalcaemia must be corrected before initiation of therapy. All patients should be prescribed daily calcium and vitamin D supplementation.
- Risk versus benefit regarding osteonecrosis of the jaw and hip fracture must be discussed with patients prior to starting treatment.
- In patients with high risk of hypocalcaemia, mineral metabolism (hyperparathyroidism, thyroid surgery, parathyroid surgery; malabsorption syndromes, excision of small intestines) recommend clinical monitoring of magnesium and phosphorus levels prior to treatment.

LABS:

- CMP. This must be done prior & resulted within 30 days of infusion appointment. After 30 days, they are no longer valid and need to be re-drawn prior to appointment in order to keep patient’s appointment and proceed with infusion.

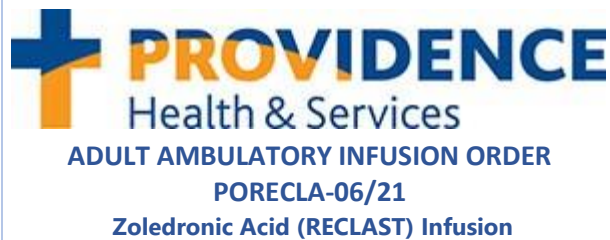
If authorizing labs to be valid for longer than the standard 30 days, please indicate below how many days the CMP lab results are valid for in order to proceed with infusion.
(Example: Labs okay if within 60 days).

Optional: Please extend lab work to be used for _____ days prior to infusion.

- **Zoledronic acid (RECLAST) not recommended in patients with creatinine clearance less than 35mL/minute**

MEDICATIONS:

- Zoledronic acid (RECLAST), 5 mg, intravenous, ONCE, over 30 minutes.



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NURSING ORDERS:

- ✓ Notify provider if patient has signs/symptoms of infection or signs of active TB.
- ✓ Vital signs: Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion.
- ✓ TREATMENT PARAMETER - Pharmacist to calculate creatinine clearance. If less than 35 mL/min, contact provider.
- ✓ Assess for new or unusual tooth or jaw pain. Inform provider if positive findings or if patient has had any recent or has upcoming invasive dental work.
- ✓ Have patients drink at least 2 glasses of fluid prior to infusion. Remind patient to take calcium and vitamin D supplements, dosing/frequency per provider instructions.
- ✓ Insert peripheral IV if no IV access.
- ✓ May use/access CVC line and give 500 units (5ml) heparin injection for central line care.
- ✓ If hypersensitivity or infusion reactions develop, temporarily hold the infusion, and notify provider immediately.
- ✓ Include hypersensitivity reaction order set. (See attached form).

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.

My physician license 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 medications and blood products described above for the patient identified on this form.

Provider's printed name: _____

Provider's signature: _____

Date: _____



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Outpatient Infusion Services Intake Team:

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

Outpatient Infusion Services

- | | | |
|---|--------------------|------------------|
| <input type="checkbox"/> PORTLAND | Phone 503-215-6046 | Fax 503-487-3582 |
| <input type="checkbox"/> WILLAMETTE FALLS | Phone 503-215-6046 | Fax 503-487-3582 |
| <input type="checkbox"/> MEDFORD | Phone 541-732-7048 | Fax 541-732-3939 |
| <input type="checkbox"/> HOOD RIVER | Phone 541-387-1338 | Fax 541-387-6137 |
| <input type="checkbox"/> SEASIDE | Phone 503-717-7671 | Call for fax # |
| <input type="checkbox"/> NEWBERG | Phone 503-537-1450 | Fax 503-537-1449 |