



Zoledronic Acid (Reclast)

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	Office Phone Number:	Fax Number:
Insurance:	Group Number:	Policy Number:
Hospitalization Status:	Patient Weight (kg):	Height (inches):
<input checked="" type="checkbox"/> Outpatient to Outpatient Infusion Center		
Allergies:		

Send patient demographics/insurance, clinical notes, and test results with orders

Diagnosis Code/Description for treatment

- Age-related Osteoporosis without current Pathological Fracture (M81.0)
 - Check if indicated due to a low-trauma hip fracture
- Osteitis Deformans of Unspecified Bone (M88.9)
- Other Osteoporosis without current Pathological Fracture (M81.8)

Orders

Initiate IV Vascular Access Flush Orders #0643 for:

- Peripheral Line
- Midline
- PICC
- Port

 Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)

CALCIUM – confirm level is within normal limits, must be corrected prior to treatment

Document Required Pre-dose Labs/Data (measured within two weeks of dose)

AGE (years)	Actual Body Weight (ABW)	Height (inches)	Serum Creatinine (Cr) mg/dL

- Avoid Zoledronic acid (Reclast) if calculated Creatinine Clearance (CrCl) is LESS THAN 35 mL/min.
- Avoid IV bisphosphonates if patient is not properly hydrated OR consider pre-dose IV fluids.

Zoledronic Acid (Reclast) 5 MG INTRAVENOUS ONCE in separate vented infusion line over 30 minutes once yearly (J3489 : 1 MG = 1 unit)

Initial Dose DATE of LAST DOSE: _____

Infusion Reaction

If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

Discharge Discharge home 30 minutes after treatment complete if stable.

Date and Physician Signature

DATE: _____
07992512

TIME: _____

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PHYSICIAN'S SIGNATURE