



134 Prince Avenue, Suite B
 Bellingham, WA 98226
 Phone (360) 933-4892
 Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Weight (kg): _____

IV Access: _____

Allergies: _____

Zoledronic Acid (Reclast) Order Form

◆ **Orders are initiated unless crossed out by provider.**

Check box to initiate order.

Please complete this form and fax to (360)933-1197. Call our office and our clinical pharmacists will be happy to make therapy recommendations.

<u>Diagnoses:</u>	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Post-menopausal/Senile Osteoporosis <input type="checkbox"/> Osteopenia <input type="checkbox"/> Paget's Disease of the Bone <input type="checkbox"/> Other: _____	ICD-9: 733.0 ICD-9: 733.01 ICD-9: 733.90 ICD-9: 731.0 ICD-9: _____
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Is the patient taking calcium/vitamin D? No Yes (specify dose): _____

Hydration:

- ◆ Instruct patient to drink two 8-ounce glasses of fluid (non-caffeinated) prior to infusion and eight glasses of fluid daily for at least 2 days after infusion

Medication Orders:

- ◆ Zoledronic Acid (Reclast) 5mg/100ml IV over at least 15 minutes
- Fluids: NaCl _____ ml at _____ ml/hour Other: _____
- Patient may take OTC acetaminophen or ibuprofen for minor muscle/joint ache or headache. Call prescriber if severe pain, numbness, tingling, or muscle spasm.
- Recommend Calcium/Vitamin D supplementation:
 - ◆ Osteoporosis: Calcium 1,200 mg daily and Vitamin D 2,000 units daily in divided doses.
 - ◆ Paget's Disease: Calcium 1,500mg daily in divided doses for 2 weeks after receiving Reclast
- ◆ Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- ◆ Flush line with D5W, 0.9% NaCl and/or Heparin 10 u/ml or 100 u/ml per Infusion Solutions protocol.
- ◆ Infusion Reaction Management per Infusion Solutions Protocol as needed.
- Other: _____

Nursing Orders:

- ◆ If no central IV access, RN to insert peripheral IV, rotate site every 72 to 120 hours or as needed.
- Other: _____

Labs:

Date of last SCr (serum creatinine): _____ **Must be within 30 days
 SCr level: _____ mg/dL Creatinine Clearance (CrCl): _____ ml/min (CrCl must be >35 ml/min)
 Other: _____ every _____

Prescriber Signature

Date

Please Print Name