



477 W. Horton Rd.
 Bellingham, WA 98226
 Phone (360) 933-4892
 Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Wt: _____ Ht: _____

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.

Diagnoses:

- | | |
|--|----------------|
| <input type="checkbox"/> Osteoporosis | ICD-10: M 81.0 |
| <input type="checkbox"/> Post-menopausal/Senile Osteoporosis | ICD-10: M 81.0 |
| <input type="checkbox"/> Paget's Disease of the Bone | ICD-10: M 88.9 |
| <input type="checkbox"/> Other: _____ | ICD-10: _____ |

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
 - ◆ Recommend 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
 - ◆ Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
 - ◆ 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:

- ◆ Please order Creatinine to be drawn at a lab (within 30 days before administration – CrCl must be >35 ml/min)
- Laboratory orders sent to: _____ (Name of lab and location)
- OR- if drawn in last 30 days: Date of last serum creatinine: _____ Result: _____ mg/dL
- * Calcium level recommended to also be drawn if patient is not taking oral calcium

 Prescriber Signature

 Date

 Please Print Name