

Zoledronic Acid (Reclast)

Provider Order Form rev. 01/02/2023

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____
Patient Address: _____ Patient Email: _____
Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Post-menopausal osteoporosis: _____ Male osteoporosis: _____
Cancer treatment-induced osteoporosis: _____ Paget's Disease: _____
Other: _____ Description: _____

REQUIRED INFORMATION

Obtain serum calcium level and renal function and creatinine clearance 7-14 days prior to infusion (must be completed at external lab and faxed prior to treatment).

THERAPY ADMINISTRATION & DOSING

Administer Zoledronic Acid (Reclast) 5mg / 100ml IV over a period of 15 minutes. Follow with 10ml NS flush to flush IV tubing.

FREQUENCY (Choose one)

Once
 Other: _____

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

Tylenol 500mg / 650mg PO
 Loratadine 10mg PO
 Pepcid 20mg PO / IVP
 Benadryl 25mg / 50mg PO / IVP
 Solumedrol 40mg / 125mg IVP
 Other: _____

NURSING

Hold infusion and notify provider for:

- Planned/recent invasive dental procedures, jaw, thigh, or groin pain.
- A history of severe bone, muscle or joint pain following Reclast treatments.
- Signs or symptoms of acute dehydration.
- Abnormal labs as described below:
 - Hypocalcemia.
 - Creatinine clearance (calculated using Cockcroft-Gault equation) less than 35 mL/min.

Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with biphosphates, Reclast, Prolia, Evenity. History of GERD, fractures, T score

Required Labs: Calcium and Vitamin D levels, Renal function

Provider Name (print)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.