Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Zoledronic Acid (ZOMETA)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. This order should be used in patients with bone lesions associated with multiple myeloma, bone metastases from solid tumors, and hypercalcemia of malignancy. Do not use this order if patient is already being treated with zoledronic acid (RECLAST).
3. Please confirm that patient has had recent dental evaluation prior to initiating therapy. Invasive dental procedures should be avoided during treatment.
4. Hypocalcemia must be corrected before initiation of therapy. Patients with multiple myeloma and bone metastases of solid tumors should be prescribed daily calcium and vitamin D supplementation.
5. When treating hypercalcemia of malignancy, a full dose of 4 mg should be used. Consult pharmacist if SCr is greater than 4.5 mg/dL. When treating bone lesions associated with multiple myeloma and bone metastases from solid tumors, dose adjustments should be made for renal impairment. [CrCl is calculated using Cockroft-Gault formula. Use actual weight unless patient is greater than 30% over ideal body weight, then use adjusted body weight. If SCr is less than 0.8 mg/dl, use 0.8 mg/dl to calculate CrCl]
    a. CrCl greater than 60 mL/min = 4 mg
    b. CrCl 50-60 mL/min = 3.5 mg
    c. CrCl 40-49 mL/min = 3.3 mg
    d. CrCl 30-39 mL/min = 3 mg
    e. CrCl less than 30 mL/min = consult pharmacist

LABS:

- ☐ CMP, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Magnesium plasma, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Phosphorous plasma, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Labs already drawn. Date: _____

PRE-HYDRATION: Have patient drink at least 2 glasses of fluid prior to infusion

MEDICATIONS:

- zoledronic acid (ZOMETA) 4 mg in NaCl 0.9% 100 mL, intravenous, ONCE, over 30 minutes

Interval: ***(must check one)***

- ☐ ONCE
- ☐ Every _____ weeks x ____ doses (minimum of 7 days between doses for hypercalcemia)

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NURSING ORDERS:

1. Review previous serum creatinine (SCr) and previous serum Calcium, Magnesium, Phosphorus and Albumin. Order CMP prior to each dose. Order Magnesium and Phosphorus levels if no results in past 28 days.
2. TREATMENT PARAMETER – Calcium must be corrected prior to administration. Hold and notify provider for corrected calcium less than 8.4 (use calcium and albumin from previous treatment for calculation).
3. Assess for jaw pain. Inform provider if positive findings or if patient is anticipating dental work.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

PROVIDER TO PHARMACIST COMMUNICATION:

1. If corrected calcium is between 8.4 and 8.8, pharmacist will review home medication list for calcium and vitamin D supplementation. If patient is not on these agents, provider will be notified.
2. Pharmacist to ensure provider has been contacted for CrCl < 30 mL/min if using medication for bone lesions associated with multiple myeloma and bone metastases from solid tumors. No dose adjustment is necessary in hypercalcemia of malignancy unless SCr is greater than 4.5 mg/dL

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 ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not 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 medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

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OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

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

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders