Zoledronic Acid (RECLAST) Infusion

**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 Paget’s disease or osteoporosis. Do not use this order if patient is already being treated with zoledronic acid (ZOMETA).
3. Please confirm that patient has had recent dental evaluation prior to initiating therapy.
4. Hypocalcemia must be corrected before initiation of therapy. All patients should be prescribed daily calcium and vitamin D supplementation.
5. Risk versus benefit regarding osteonecrosis of the jaw and hip fracture must be discussed prior to treatment.
6. In patients with high risk of hypocalcemia, mineral metabolism (hypoparathyroidism, thyroid surgery, parathyroid surgery; malabsorption syndromes, excision of small intestines) recommend clinical monitoring of magnesium and phosphorus levels prior to treatment.

**LABS:**

- CMP, Routine, ONCE

**NURSING ORDERS:**

1. TREATMENT PARAMETER - Pharmacist to calculate corrected calcium. Hold and contact provider for corrected calcium less than 8.4 mg/dL or creatinine clearance less than 35 mL/min.
2. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.
3. Have patient drink at least 2 glasses of fluid prior to infusion. Remind patient to take calcium and vitamin D supplements. Paget's disease - calcium 1500 mg/day (in divided doses, 2-3 times/day) and vitamin D 800 IU/day - especially important for the first 2 weeks after receiving Reclast. Osteoporosis - calcium 1200 mg and vitamin D 800 IU daily.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

**MEDICATIONS:**

- zoledronic acid (RECLAST), 5 mg, intravenous, ONCE, over 30 minutes
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: __________

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

☐ 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

☐ 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

☐ 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