ADULT AMBULATORY INFUSION ORDER
Zoledronic Acid (ZOMETA) Infusion

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 plan should be used in patients with bone lesions associated with multiple myeloma, bone metastases from solid tumors, and hypercalcemia of malignancy.
3. 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.
4. Risk versus benefit regarding osteonecrosis of the jaw and hip fracture must be discussed prior to treatment.
5. Must complete and check the following box:
   □ Provider confirms that the patient has had a recent oral or dental evaluation and/or has no contraindications to therapy related to dental issues.

PROVIDER TO PHARMACIST COMMUNICATION:
1. Creatinine clearance 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 serum creatinine below 0.7 mg/dL, use 0.7 mg/dL to calculate creatinine clearance.

   Creatinine Clearance: Dose of zoledronic acid:
   Greater than 60 mL/min  4 mg
   50 - 60 ml/min  3.5 mg
   40 - 49 ml/min  3.3 mg
   30 - 39 ml/min  3.0 mg

LABS:
□ CMP, Routine, ONCE, every ______ (visit)(days)(weeks)(months) – Circle One
□ Labs already drawn. Date: ________

NURSING ORDERS:
1. TREATMENT PARAMETER – Pharmacist to calculate corrected calcium. Hold and contact provider for corrected calcium less than 8.4 mg/dL.
2. If no results in past 28 days, order CMP.
3. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

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

ONLINE 02/2023 [supersedes 07/2022]  PO-8088
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**ACCOUNT NO.**
**MED. REC. NO.**
**NAME**
**BIRTHDATE**

**Patient Identification**

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

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**MEDICATIONS:**

- zoledronic acid (ZOMETA) 4 mg in sodium chloride 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)

**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.

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**Provider signature:** ____________________________  **Date/Time:** ____________________________

**Printed Name:** ____________________________  **Phone:** ______________  **Fax:** ____________

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Central Intake:
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](http://www.ohsuknight.com/infusionorders)