



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

P07071



ADULT AMBULATORY INFUSION ORDER
Zoledronic Acid (RECLAST) Infusion
for Osteoporosis Indications

Page 1 of 3

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

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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 Paget's disease or osteoporosis. Do not use this order if patient is already being treated with zoledronic acid (ZOMETA).
3. Hypocalcemia must be corrected before initiation of therapy. All patients should be prescribed daily calcium and vitamin D supplementation.
4. The corrected calcium level should be greater than or equal to 8.4 mg/dL.
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.
7. A complete metabolic panel must be obtained within 60 days prior to each treatment.
8. PROVIDER TO PHARMACIST COMMUNICATION - 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. No dose adjustment required for CrCl greater than or equal to 35 mL/min.
9. For Adventist patients: Provider must calculate the creatinine clearance using the Cockroft-Gault formula.
10. **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 prior to initiating therapy.

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. If no results in past 60 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. Have patient drink at least 2 glasses of fluid prior to infusion. Remind patient to take calcium and vitamin D supplements as prescribed by provider.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.



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MEDICATIONS:

- zoledronic acid (RECLAST), 5 mg, intravenous, ONCE, over 15 minutes

HYPERSensitivity MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydRAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

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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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