Oregon Health & Science University Hospital and Clinics Provider's Orders PO7071 ADULT AMBULATORY INFUSION ORDER **Zoledronic Acid (ZOMETA) Infusion for Oncology Indications** Page 1 of 3	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 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

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

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)

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