

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/> Order Renewal	
Patient preferred clinic:			

Zoledronic Acid (generic for Reclast®) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:	
Patient Name:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight: LB or KG	Gender:	Allergies: <input type="checkbox"/> See list <input type="checkbox"/> NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

M81.0 - Age-related Osteoporosis without current fractures	M89.9 - Disorder of bone, unspecified
M81.8 - Other osteoporosis without current fracture	M94.9 - Disorder of cartilage, unspecified
M88. - Paget's disease	Z92.241 - History of systemic steroid therapy (SECONDARY)
Z79.52 - Long term use of systemic steroids (SECONDARY)	- Other: _____

REQUIRED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	BMP results within last 30-60 days is preferred

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
	NEXT INFUSION DATE:
	IF ORDER CHANGE:
	Continue current order until insurance approved

MEDICATION ORDERS:

NOTE: Patient **may be ineligible** to receive Zoledronic Acid if creatinine clearance is <35 ml/min or serum calcium is below normal range. ONJ is a risk for patients receiving zoledronic acid. A routine oral exam is recommended to be performed by the prescriber prior to initiation of zoledronic acid treatment.

MEDICATION/DOSE:

☒ **Zoledronic Acid 5mg/100ml IV administration single dose (x1) over 30 minutes**

☐ Prescriber clearance waived for recent or planned dental procedures.

LAB PARAMETERS: (Pharmacist to perform clinical lab monitoring)

Creatinine clearance <=35 ml/min: dose will be held unless written clearance is provided by MD

Serum Calcium is below normal range: dose will be held unless written clearance is provided by MD

LINE USE/CARE ORDERS:

- ☒ Start PIV/Access CVC
- ☒ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.



PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)

DATE:

Dispense as written/Brand medically necessary	Substitution permitted	