

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:

Patient Name:					
Patient's Phone:			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: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	BMP results within last 30-60 days is preferred	THERAPY:	
			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:

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: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure <input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.
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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