Rutland Regional Medical Center
www.RRMC.org | 160 Allen Street, Rutland, VT | 802.775.7111

Zoledronic Acid (Reclast®)

Provider Order Form rev.

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐NKDA Weight (kg): Height (cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date:

Insurance carrier: PA #: PA date:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

☐ Post-menopausal osteoporosis: ☐ Male osteoporosis:

☐ Cancer treatment-induced osteoporosis: ☐ Paget's Disease:

☐ Other: Description:

REQUIRED INFORMATION

☐Last serum Ca+ drawn on __________Result: __________

☐Obtain serum calcium level and creatinine clearance within 30 days of infusion date

☐Bone density testing results (including T scores)

THERAPY ADMINISTRATION & DOSING

☐Zoledronic Acid (Reclast) 5mg IV

FREQUENCY *(Choose one)*

☐ Once

☐ Other: ______________________

LABORATORY ORDERS

☐ Other: ______________________________

ADDITIONAL ORDERS:

PRE-MEDICATION ORDERS

☐ Acetaminophen ☐ 500mg / ☐ 650mg PO

☐ Cetirizine 10mg PO

☐ Famotidine 20mg ☐ PO / ☐ IVP

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Methylprednisolone ☐ 40mg / ☐ 125mg IVP

☐ Other: ______________________________

NURSING

☐Hold infusion and notify provider for:

- Planned/recent invasive dental procedures, jaw, thigh, or groin pain.
- A history of severe bone, muscle or joint pain following Reclast treatments.
- Signs or symptoms of acute dehydration.
- Abnormal labs as described below:
  - Hypocalcemia.
  - Creatinine clearance (calculated using Cockcroft-Gault equation) less than 35 mL/min.

☐Provide nursing care and post-procedure observation per policy

☐In the event of an infusion reaction, per RRMC Infusion Reaction Management policy, the patient may receive:

- Acetaminophen 1000 mg orally
- Epinephrine 0.5 mg IM
- Diphenhydramine 25-50 mg IV push
- Normal saline IV at 150 mL/hr
- Methylprednisolone 125 mg IV push

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)* Required

Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with oral bisphosphonates, history of GERD, fractures, T score. **Required Labs:** Calcium and Vitamin D levels, Renal function

Provider Name *(print)* **Provider Signature** **Time** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability

Form #5513 created 8/25

White- Patient
Yellow- Medical Records

Patient Label