Patient Name:
DOB:
Date of Last Infusion
Insurance:

Clinic Location:
Merrimack, NH ☐
Concord, NH ☐

Zoledronic Acid (Reclast®) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_________ Postmenopausal Osteoporosis (ICD-10)

_________ Osteoporosis in Men (ICD-10)

_________ Paget's Disease (ICD-10)

_________ Glucocorticoid-induced Osteoporosis (ICD-10)

Date of last Reclast infusion: __________________ Weight: __________________

Serum creatinine and calcium results required. Results should be obtained no more than one month prior to infusion. Please choose one:

☐Lab results attached. Date collected: __________________
☐Patient has been provided with lab order and instructions to have drawn within one month of infusion. To prevent delays in patient care, please indicate on lab order **"CC results to Infusion Services: fax (603) 570-1470"**

Nursing Orders:

- Hold medication 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
  - Hypocalcemia
  - Creatinine clearance (calculated using Cockcroft-Gault equation) less than 35 mL/min.
- If infusion-related reaction occurs, stop infusion, and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Dose: Administer **Zoledronic Acid 5 mg/100 ml** intravenously over a period of 15 minutes.

Additional Orders:

Provider name (print): ____ Date:____________________

Provider signature: ____ Time: ____________________

Revised 4/23/2018

(order valid for one year/tx unless otherwise indicated)