Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy
134 Prince Avenue, Suite B
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Wt: _____ Ht: _____

Allergies: _____

Zoledronic Acid (Reclast) Order Form

- **Orders are initiated unless crossed out by provider.**
- ❑ **Check box to initiate order.**

Please complete this form and fax to (360)933-1197. Call our office and our clinical pharmacists will be happy to make therapy recommendations.

Diagnoses:

❑ Osteoporosis	ICD-10: M 81.0
❑ Post-menopausal/Senile Osteoporosis	ICD-10: M 81.0
❑ Paget's Disease of the Bone	ICD-10: M 88.9
❑ Other: _____	ICD-10: _____

Is the patient taking calcium/vitamin D? ❑ No ❑ Yes (specify dose): _____

Hydration:

- Instruct patient to drink two 8-ounce glasses of fluid (non-caffeinated) prior to infusion and eight glasses of fluid daily for at least 2 days after infusion

Medication Orders:

- Zoledronic Acid (Reclast) 5mg/100ml IV over at least 15 minutes
- Recommend OTC acetaminophen or ibuprofen for minor muscle/joint ache or headache. Call prescriber if severe pain, numbness, tingling, or muscle spasm.
- Recommend Calcium/Vitamin D supplementation:
  - Osteoporosis: Calcium 1,200 mg daily and Vitamin D 2,000 units daily in divided doses.
  - Paget's Disease: Calcium 1,500mg daily in divided doses for 2 weeks after receiving Reclast
- Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush line with D5W, 0.9% NaCl and/or Heparin 10 u/ml or 100 u/ml per Infusion Solutions protocol.
- Infusion Reaction Management per Infusion Solutions Protocol as needed.

❑ Other: _____

Nursing Orders:

- If no central IV access, RN to insert peripheral IV, rotate site every 72 to 120 hours or as needed.

❑ Other: _____

Labs:

- Creatinine (within 30 days before administration – CrCl must be >35 ml/min)
  -OR- if drawn in last 30 days: Date of last serum creatinine: _____ Result: _____mg/dL

❑ Calcium level (recommended if patient is not taking oral calcium)

❑ Other: _____ every _____

_____ _____

Prescriber Signature *Date*

_____

Please Print Name