Patient Name:

Patient's DOB: Phone:

Physician:

FAX: Date of Exam:

Columbus Community Hospital
Columbus, Nebraska
DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here ☐

PHYSICIANS ORDERS
(including Medications)

Zoledronic Acid (RECLAST) Infusion (1/2025) Page 1 of 2

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET** and **H&P or most recent chart note.**
2. This order should be used in patients with Paget's disease or osteoporosis. Do not use this order if patient is already being treated with zoledronic acid (ZOMETA).
3. Hypocalcemia must be corrected before initiation of therapy. All patients should be prescribed daily calcium and vitamin D supplementation.
4. The calcium level should be greater than or equal to 8.4 mg/dL.
5. Risk versus benefit regarding osteonecrosis of the jaw and hip fracture must be discussed prior to treatment.
6. In patients with high risk of hypocalcemia, mineral metabolism (hypoparathyroidism, thyroid surgery, parathyroid surgery: malabsorption syndromes, excision of small intestines) recommend clinical monitoring of magnesium and phosphorus levels prior to treatment.
7. A complete metabolic panel must be obtained within 60 days prior to each treatment.
8. Creatinine clearance is calculated using Cockroft Gault formula. If serum creatinine below 0.7 mg/dL, use 0.7 mg/dL to calculate creatinine clearance. Contraindicated if creatine clearance is less than 35 mL/min.
9. **Must complete and check the following box:**

☐ Provider confirms that the patient has had a recent oral or dental evaluation and/or has no contraindications to therapy related to dental issues prior to initiating therapy.

LABS:

☐ CMP, Routine, ONCE

Or fill in information below

LAB RESULTS:

Calcium: _____Serum creatinine: _____ Ht: _____ Wt:_____

Date of results: _____

FORMULAS:

Ideal body weight (IBW)

IBW (male) = 50 + (2.3 x height in inches > 5 ft)

IBW (female) = 45.5 + 2.3 x height in inches > 5 ft)

Creatine clearance:

$$\text{CrCl (male)} = \frac{(140\text{-age}) \times \text{IBW}}{\text{Serum creatinine} \times 72}$$

$$\text{CrCl (female)} = \frac{0.85 \times (140\text{-age}) \times \text{IBW}}{\text{Serum creatinine} \times 72}$$

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold and contact provider for corrected calcium less than 8.4 mg/dL or creatinine clearance less than 35 mL/min.
2. If no results in past 60 days, order CMP.

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PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

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PHYSICIANS ORDERS
(including Medications)

3. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

1. **Verify with patient that they have taken at least two full glasses of fluid (water) in the last 3 hours to ensure hydration prior to start of infusion.**
2. **Prior to infusion:**
   - ☐ **Tylenol 650mg PO x 1**
   - ☐ **Ibuprofen 200mg PO x 1**
3. **zoledronic acid (RECLAST) 5mg/100ml IV over 30 minutes x 1**

Patient instructions: Paget's disease

1. Remind the patient to start taking the following after infusion:
   a. Calcium 1500mg daily in divided doses (500mg 3 times a day with meals)
   b. Vitamin D 800 units daily

HYPERSENSITIVITY:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop **STOP THE INFUSION**.
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
5. Continue to assess as grade of severity may progress.
6. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:

- **Acetaminophen**, **975 mg**, PO, x 1 dose, AS NEEDED for hypersensitivity or infusion reaction.
- **DiphenhydrAMINE inj, 50 mg**, IV, AS NEEDED for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
- **Hydrocortisone Sodium Succinate, 100 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Famotidine, 20 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
- **0.9% Normal Saline, 1000 mL**, IV, 150mL/hr, AS NEEDED for hypersensitivity or infusion reaction.
- **EPINEPHrine HCl (1mg/1mL), 0.3 mg**, IM injection, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.

My NPI number is _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION);
and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____**Fax:**_____