St. Charles HEALTH SYSTEM	**St. Charles Health System** Adult Ambulatory Infusion Order Zoledronic Acid (ZOMETA) For Osteoporosis	Patient Name: Date of Birth: *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ Allergies: _____
Weight: _____kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety
1. FACE SHEET with complete INSURANCE information and patient CONTACT information
2. Recent VISIT NOTE to support treatment (if not available in Epic)
3. LAB RESULTS for any required prescreening (if not available in Epic)
4. DIAGNOSIS CODE _____
5. Patient NAME and DATE OF BIRTH on EVERY page faxed

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 corrected calcium level should be greater than or equal to 8.6 mg/dL (ionized calcium less than or equal to 1.1 mmol/L).
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 90 days prior to each treatment.
8. 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.

NURSING ORDERS:

1. TREATMENT PARAMETER #1 – Hold and contact provider for corrected calcium less than 8.6 mg/dL (or ionized calcium less than 1.1 mmol/L) or unmeasured calcium in the last 3 months.
2. TREATMENT PARAMETER #2 – Hold and contact provider for BSA-adjusted eGFR less than 35 mL/min.
3. TREATMENT PARAMETER #3 – Ensure vitamin D level meets parameters for treatment
   a. Vitamin D level less than 27: Hold infusion and contact provider
   b. Vitamin D level 27-40: Ensure most recent level is measured in the last 6 months before infusion

   c. Vitamin D level over 40: Ensure most recent level is measured in the last 12 months before infusion
4. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.
5. Encourage good hydration during and after infusion. Remind patient to take calcium and vitamin D supplements as prescribed by provider.
6. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

zoledronic acid (RECLAST), 5 mg, intravenous, ONCE, over 15 minutes

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

_____

Patient will be treated at the following infusion location:

☑ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

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Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed