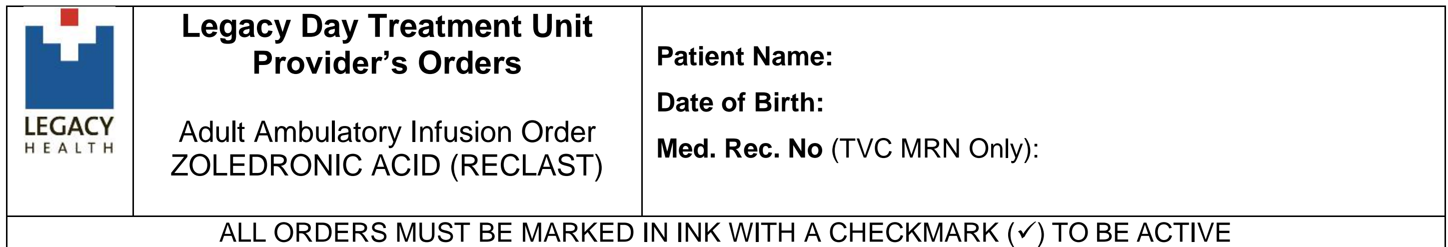

	Legacy Day Treatment Unit Provider's Orders Adult Ambulatory Infusion Order ZOLEDRONIC ACID (RECLAST)	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):

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

Anticipated Start Date: ___________ **Patient to follow up with provider on date:** ___________
*****This plan will expire after 365 days, unless otherwise specified below*****
Orders expire: ______________________

Weight: ___________kg **Height:** ___________cm

Allergies: ____

Diagnosis: ___________________________ **Diagnosis Code:** ________________

GUIDELINES FOR PRESCRIBING:

1. Send **FACE SHEET, INSURANCE CARD and most recent provider chart or progress 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. The corrected calcium level should be greater than or equal to 8.4 mg/dL.
4. Consider prescribing daily calcium and vitamin D supplementation. Recommended dose: Osteoporosis – calcium 1200 mg and vitamin D 400 – 800 IU daily
5. Complete metabolic panel must be collected within 60 days of treatment unless otherwise specified. 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.
6. Risk versus benefit regarding osteonecrosis of the jaw and hip fracture must be discussed prior to Treatment
7. Please confirm that patient has had a recent oral examination prior to initiating therapy, if indicated.
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.

MEDICATIONS:

- zoledronic acid (RECLAST) 5 mg/100 ml IV, ONCE, over 15 minutes. Doses must be at least 366 days apart

NURSING ORDERS (TREATMENT PARAMETERS):

1. Nursing order: Review previous serum creatinine (SCr) and previous serum calcium and serum albumin. If no results in past 60 days, order STAT CMP
2. Treatment parameter: Hold and notify MD for CrCl <35 mL/min [Creatinine clearance is calculated using Cockcroft-Gault formula (Use actual weight unless patient is greater than 30% over ideal body weight, then use adjusted body weight with 0.4 correction factor). If serum creatinine is <0.7 mg/dl, use 0.7 mg/dl to calculate creatinine clearance]
3. Treatment parameter: Hold and notify MD for corrected calcium less than 8.4
4. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider of 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. If corrected calcium is between 8.4 and 8.8 review home medication for calcium and vitamin D supplementation. If patient is not on these agents, notify provider.
7. Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters

Please check the appropriate box for the patient's preferred clinic location:

☐ **Legacy Day Treatment Unit – The Vancouver Clinic Building**
A department of Salmon Creek Medical Center
700 NE 87th Avenue, Suite 360
Vancouver, WA 98664
Phone number: 360-896-7070
Fax number: 360-487-5773

☐ **Legacy Salmon Creek Day Treatment Unit**
Legacy Salmon Creek Medical Center
2121 NE 139th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773

☐ **Legacy Emanuel Day Treatment Unit**
A department of Emanuel Medical Center
501 N Graham Street, Suite 540
Portland, OR 97227
Phone number: 503-413-4608
Fax number: 503-413-4887

☐ **Legacy STEPS Clinic**
A department of Silverton Medical Center
Legacy Woodburn Health Center
1475 Mt Hood Ave
Woodburn, OR 97071
Phone number: 503-982-1280
Fax number: 503-225-8723

Provider signature: ___________________________ **Date/Time:** ____________________

Printed Name: _________________________ **Phone:** ______________ **Fax:** ____________

Organization/Department: _____________________________________

Dental Clearance Letter

Re: ____ DOB:___________________

To Whom It May Concern:

Our mutual patient noted above is scheduled to start denosumab or a bisphosphonate medication for the medical treatment of ______________________________.

It has been reported that a small number of patients taking these medications may develop a condition known as osteonecrosis following certain dental treatments. We are requesting a dental clearance prior to the initiation of the medical treatment. Please perform a complete dental evaluation and treat any dental conditions that may lead to future teeth extractions or other invasive dental procedures.

Thank you for your assistance.

____

Name of referring medical practitioner

Date of last dental exam: ___________________

☐ Patient is free of active dental infection or need for further dental treatments and is cleared to receive denosumab or a bisphosphonate medication

☐ Patient is NOT cleared to receive denosumab or a bisphosphonate medication

Additional comments:

____

____

____

_________________________	____________________________	______________
Printed name of Dentist	Signature of Dentist	Date

Please fill out and fax this letter to the infusion center where patient will receive treatment. Attn: Pharmacist

Fax:_______________________________

 Last updated 5/2024