LEGACY HEALTH	**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. Please confirm that patient has had a recent oral examination prior to initiating therapy. Schedule for a dental exam if indicated
3. Hypocalcemia must be corrected before initiation of therapy
4. All patients should be prescribed daily calcium and vitamin D supplementation. Recommended dosing: Osteoporosis-- calcium 1200 mg and vitamin D 400 IU-800 IU daily
5. CMP must be within 30 days of treatment unless otherwise specified. Date drawn: _____

Dental Clearance: (Must select one)

☐ Dental clearance required prior to initiation (form on page 3) – **Recommended, not required**
☐ Patient may be treated without documentation of dental clearance

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 30 days, order STAT CMP
2. Treatment parameters: Hold and notify MD for serum creatinine greater than 1.5 or 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). If serum creatinine is <0.8 mg/dl, use 0.8 mg/dl to calculate creatinine clearance]
3. Treatment parameters: Hold and notify MD for corrected calcium less than 8.4
4. Nursing communication order: Encourage good hydration during and after infusion.
5. Nursing communication order: 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
6. Nursing communication order: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters
7. Nursing communication orders: Manage hypersensitivity reactions per LH 906.6606

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HYPERSENSITIVITY MEDICATIONS: Refer to LH policy 906.6606 Initiation of Emergency Measures for Adult Oncology, Radiation Oncology and Infusion Clinic Patients

1. diphenhydramine 25-50 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. hydrocortisone 100 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. naloxone (Narcan) 0.4 mg IV, AS NEEDED x1 dose for diminished respiratory rate
6. Nursing communication order: Please follow treatment algorithm for acute infusion reaction

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

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

☐ **Legacy Silverton STEPS Clinic**
Legacy Silverton Medical Center
342 Fairview Street
Silverton, OR 97381
Phone number: 503-873-1670
Fax number: 503-874-2483

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

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

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

Organization/Department: _____

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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:_____