Outpatient Zoledronic Acid (Reclast) Order Set

Klickitat Valley Health
Phone: 509-772-2695 Fax: 509-773-3354

General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone #_____

Order Start Date _____ Order Expiration Date *(max one year)* _____

Allergies: _____

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 8.4 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. PROVIDER TO PHARMACIST COMMUNICATION - Creatinine clearance is calculated using CockroftGault formula (Use actual weight unless patient is greater than 30% over ideal body weight, then use adjusted body weight). If serum creatinine below 0.7 mg/dL, use 0.7 mg/dL to calculate creatinine clearance. No dose adjustment required for CrCl greater than or equal to 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.

DIAGNOSIS CODE: **IF using 'Other' must include ICD10 code**

☐ M81.0 Osteoporosis

☐ Other: _____

Nursing Orders

☒ TREATMENT PARAMETER: Pharmacist to calculate corrected calcium. Hold and contact provider for corrected calcium less than 8.4 mg/dL or creatinine clearance less than 35 mL/min.

☒ If no results in the past 60 days, order CMP.

☒ Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work

☒ Have patient drink at least 2 glasses of fluid prior to infusion. Remind patient to take calcium and vitamin D supplements as prescribed by provider

IV ACCESS: ☐ Place peripheral IV ☐ Access Implanted Port

If nurse to access implanted port please complete Port Access Order Set as well

☒ Vital Signs: Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and upon completion of infusion. Consider observing patient for 30-minutes following infusion.

Patient Name:
DOB:

Medication Orders

☒ Zoledronic acid (Reclast) 5 mg/100mL IV once over 30 minutes.

MANAGEMENT OF SIDE EFFECTS

☒ In the event of an adverse reaction, which can be characterized by unexpected physiological responses such as a notable decrease in blood pressure, irritation at the injection site, muscle cramps, gastrointestinal distress (nausea and diarrhea), or other concerning symptoms: Hold infusion x 30 mins, if symptoms improve resume infusion at half previous rate, if symptoms persist consider administering 500ml IV sodium chloride 0.9% bolus and call provider. If afterhours call hospitalist.

IF ANAPHYLACTIC REACTION OCCURS

☒ Stop infusion immediately, notify provider and/or Hospitalist on duty if afterhours, administer oxygen prn, administer Benadryl 50 mg IV or IM once STAT, administer Epinephrine (1:1000) 0.5mg IM once STAT, possible admission to emergency department for further evaluation/treatment.

Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in _____ *(specify state)*

My physician license number is # _____ 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** _____

Printed name: _____ **Phone:** _____ **Fax:** _____

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: _____ **Date** _____

Printed name: _____

Patient Name:
DOB: