Oregon Medical Group Infusion Center

1007 Harlow Road, Springfield, Oregon 97477
Phone: 541-741-0387 Fax: 541-242-4634

Zoledronic Acid (Reclast) Orders

Name: _____ DOB: _____

ICD-10 Code: _____ Weight: _____

Check Appropriate Diagnosis:

	Senile Osteoporosis (postmenopausal women/men) 733.01
	Glucocorticoid induced osteoporosis 733.01 + E93.2
	Low trauma hip fracture (use both codes for senile osteoporosis and for fracture site. Fracture Site:_____
	Pathological Fracture: Neck of Femur 733.01 + 733.14
	Pathological Fracture: other specified part of Femur 733.01 + 733.15
	Fracture due to injury: Neck of Femur 733.01 + 820.0-820.9
	Prevention of Glucocorticoid induced osteoporosis (primary diagnosis code + V58.65) • What is the disease process being treated by Glucocorticoids?
	Paget's Disease of bone 731.0
	Other: (please include ICD-9 code)

1. Vital signs: Initial, Q 15-30 minutes, PRN.
2. Peripheral IV site with saline lock, may use existing PICC line or port-a-cath if available.
3. Infuse Reclast/Zoledronic Acid 5 mg IV over no less than 15 minutes.
4. The patient must have a current (within 90 days) CMP with a Creatinine Clearance ≥ 35 mL/min and serum calcium that is within normal range or the Infusion Center will not be able to infuse Reclast.
   Creatinine Clearance is: _____ Calculated by:_____
   Date:_____
5. Pre-medications to be given 30 minutes prior to infusion (optional)
   - ☐ OMG Infusion Center Pre-Medication Protocol

   OR
   - ☐ Administer the following routine pre-medications prior to each infusion
     - ☐ Acetaminophen (Tylenol) 650 mg PO
     - ☐ Antihistamine (Select one)
       - ☐ Diphenhydramine (Benadryl) 25 mg PO
       - ☐ Diphenhydramine (Benadryl) 25 mg IV infusion over < 10 mins
       - ☐ Loratadine (Claritin) 10 mg PO
     - ☐ Methylprednisolone (Solu-Medrol) 40 mg IV infusion over < 10 min, not to exceed 50 mg/min
     - ☐ Methylprednisolone (Solu-Medrol) 100mg IV infusion over < 10 min, not to exceed 50mg/min
     - ☐ Ondansetron 4 mg IV **OR** ☐ Ondansetron 8 mg IV
   - ☐ Other: _____
6. For infusion reaction (**Must select one to be considered a complete order**)
   - ☐ Acute Infusion Reaction Protocol
   - ☐ Other _____
7. Encourage patient to increase fluids for next 48 hours. Continue Calcium and Vitamin D supplements.

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For non-OMG providers, please attach most recent labs, DEXA scan, and documentation of previous meds tried. Thank you.

Provider Signature: _____ Date: _____
(NO PROVIDER STAMPS) (Orders expire after 365 days)

Provider's Printed Name: _____Time: _____

Patient Name: _____DOB: _____