Zoledronic Acid (Reclast)

Provider Order Form rev. 10/30/2023

Novella Infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Post-menopausal osteoporosis: Male osteoporosis:

Cancer treatment-induced osteoporosis: Paget's Disease:

Other: Description:

REQUIRED INFORMATION

☑ Obtain serum calcium level and renal function and creatinine clearance 7-14 days prior to infusion *(must be completed at external lab and faxed prior to treatment)*.

THERAPY ADMINISTRATION & DOSING

☑ Administer Zoledronic Acid (Reclast) 5mg / 100ml IV over a period of 15 minutes. Follow with 10ml NS flush to flush IV tubing.

FREQUENCY *(Choose one)*

☐ Once

☐ Other: ________________________

LABORATORY ORDERS

☐ Other: ________________________________

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: ________________________________

NURSING

☑ Hold infusion and notify provider for:

- Planned/recent invasive dental procedures, jaw, thigh, or groin pain.
- A history of severe bone, muscle or joint pain following Reclast treatments.
- Signs or symptoms of acute dehydration.
- Abnormal labs as described below:
  - Hypocalcemia.
  - Creatinine clearance (calculated using Cockcroft-Gault equation) less than 35 mL/min.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with biphosphates, Reclast, Prolia, Evenity. History of GERD, fractures, T score

Required Labs: Calcium and Vitamin D levels, Renal function

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.