**Trinity Health Muskegon & Shelby Infusion Clinics**
Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444
Shelby: 72 S. State St. Shelby, MI 49455
Fax (shared): 231-672-3970

# Zoledronic Acid (RECLAST®)

*With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies*

**Order Date:** ____/____/____ **Site of Service:** ☐ TH Muskegon ☐ TH Shelby

**Referral Status:** ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

| | |
|---|---|
| **Patient Name**: _____<br>**Date of Birth**: ____/____/____<br>**Weight:** _____kg **Height:** _____cm<br>**Allergies:** _____ | **Primary Insurance:** _____<br>**Member ID:** _____<br>**Secondary Insurance:** _____<br>**Member ID:** _____ |
| **Diagnosis**<br><br>Diagnosis Code (**ICD-10**): _____<br>Indication: _____<br>Target start date: _____ | **Labs (within 30 days of treatment)**<br>☐Albumin<br>☐ Creatinine (serum)<br>☐Calcium<br>☐Other: _____ |
| **Pre-Medications:**<br>No routine pre-medications are routinely given. Pre-medications may be ordered at physician discretion.<br><br>☐Other: _____ | **Creatinine Clearance (Cockroft-Gault)**<br><br>$\frac{(140-\text{Age}) \times \text{Weight(kg)}}{72 \times \text{Serum Creatinine}}$ x *[0.85 if female patient]*<br><br>**Utilize actual body weight for creatinine clearance calculation* |

**Note to provider:** Patient should receive oral calcium and vitamin D therapy.

**Hold and Notify Physician for:** CrCL below 35 ml/min (therapy not recommended); Calcium below 8.4 mg/dL (Calcium supplementation needed prior to treatment)

℞ **Zoledronic acid (RECLAST ®) 5 mg/ 100ml** IVPB over at least 15 minutes

**Nursing Orders**

Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary: sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN

Provider Name: _____ Provider Signature: _____
Office Phone Number: _____ Office Fax Number: _____
Attending Physician Name: _____
*(If ordering provider is an advanced practice practitioner)*
*Note: This order is valid for 12 months from date of physician signature.*