Phone: 608-690-7210
Fax: 608-807-5179
www.MySmartInfusion.com

Reclast (zoledronic acid)

Infusion Order Form

Location

☐ Eau Claire ☐ Weston
☐ Middleton ☐ Onalaska

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Post-menopausal/Senile Osteoporosis ICD 10 Code: M81.0
☐ Osteoporosis ICD 10 Code: M81.0
☐ Paget's Disease of the Bone ICD 10 Code: M88.9

Required Tests

Pregnancy Test Status & Date: _____

Required Labs

CrCl (must be >35ml/min) (within 30 days & attach results)
Calcium Level (within 6 months & attach results)

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ **PO** ☐ **IV**

Methylprednisolone (Solu-Medrol) ☐ 125mg IV

Ondansetron (Zofran) ☐ 4mg ☐ **PO** ☐ **IV**

Drink 2, 8oz glasses of water 1 to 2 hours before treatment

Other: _____ Route: _____

Dose: _____ Frequency: _____

Zoledronic Acid Medication Order

Refill x12 months unless otherwise noted: _____

Patient Weight: _____KG

Dosage

☐ 5mg IV

Frequency

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical & Progress Notes (including last infusion note)
☐ Copy of Insurance Card (Front/Back)

Adverse Reaction Management & Nursing Orders

Full protocols are available for review at mysmartinfusion.com or upon request.

☒ Administer the following emergency medications per Smart Infusion Therapy Services protocol:
- ☒ Acetaminophen 650mg PO,
- ☒ Diphenhydramine 25mg-50mg PO or IV
- ☒ Ondansetron 4mg IV
- ☒ Sodium Chloride 0.9% 1000mL IV
- ☒ Methylprednisolone 125mg IV
- ☒ Albuterol Sulfate 2.5mg nebulized
- ☒ Oxygen 1-6LPM continuous flow
- ☒ Epinephrine 0.3mg/0.3mL IM

☐ Other: _____

☒ Manage VAD per protocol:

☒ Start/Access and Discontinue PIV/CVC

☒ Flush with NS and/or Heparin per protocol based on line type

☒ Other: _____

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____