LIFEBRIDGE HEALTH
CARE BRAVELY

IV ZOLEDRONIC ACID (Reclast®) ORDER FORM

Patient Label

Patient Name: _____ DOB: _____

Diagnosis: _____ Diagnosis Code: _____ Height: _____

Allergies: _____ Weight: _____

Reclast® is not for use in patients already receiving Xgeva®, Prolia® or Zometa®

Pre-appointment Documentation:
Please fax most recent office visit note documenting the patient's diagnosis, a copy of the lab results below, as well as a copy of the patient's demographic information along with this order form.

Pre-appointment Lab Results:
Patients on antiresorptive therapy should have bone densitometry/DEXA scan repeated every 2 years.

☐ **Date of most recent DEXA scan:** _____

The following lab tests must be ordered, completed and results documented within 30 days prior to the administration of zoledronic acid. Fax a copy of lab results with this order form. *Pre-existing hypocalcemia and vitamin D deficiency should be corrected prior to start of treatment.*

☐ Serum creatinine **Date obtained:** _____ **Result:** _____

☐ BUN **Date obtained:** _____ **Result:** _____

☐ Calcium **Date obtained:** _____ **Result:** _____

Calculated Creatinine Clearance (CrCl) using Cockroft & Gault Formula:

$$CrCl\ \left(\frac{mL}{\min}\right) = \frac{(140 - age)\ x\ weight\ (kg)}{72\ x\ SCr\ (\frac{mg}{dL})}\ x\ 0.85\ if\ female$$

This drug may not be given if the following exists: Renal impairment / Creatinine Clearance less than 35mL/min.

Does the patient have any dental concerns that would prohibit receiving zoledronic acid? ☐ No ☐ Yes

If yes, explain: _____

List prescribed supplemental calcium and vitamin D medications and dosages below:

Calcium: _____

Vitamin D: _____

List the date of last dose of previously prescribed antiresorptive therapy below:

Name of therapy: _____ Date last administered: _____ ☐ None

Treatment:

☒ Zoledronic Acid 5mg/100mL IV over 15 to 30 minutes once

☒ **Hypersensitivity/Anaphylaxis Medications and Extravasation Management (PRN):** Follow Adult Hypersensitivity Protocol as needed per Nursing Protocol for the treatment of allergic/hypersensitivity reaction. Follow established hospital protocol for extravasation.

Physician's Name (Print): _____ Signature: _____ Date: _____

Contact Number: _____ Fax Number: _____

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