

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_ Height (cm) : \_\_\_\_\_ Weight (kg) : \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

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**Financial authorizations require clinical documentation of medical necessity. To ensure compliance, the criteria below must be indicated as completed by office representative. Incomplete documentation will be returned to the referring office for completion, resulting in delays to the patient receiving treatment.**

- Ordering provider is credentialed at Sinai Hospital (Alvin and Lois Lapidus Cancer Center) or Carroll Hospital (William E. Kahlert Regional Cancer Center) to admit and write orders.
- Demographics / insurance information attached, or available in Cerner.
- Provider note dated within 30 days indicating medical need attached, or date if available in Cerner: \_\_\_\_\_
- Patients on antiresorptive therapy should have bone densitometry / DEXA scan repeated every 2 years. Most recent dexa scan results attached, or date if available in Cerner: \_\_\_\_\_
- Serum creatinine, BUN, and calcium level must be ordered, completed and results available within 30 days prior to the administration of zoledronic acid. Lab results are attached, or date if available in Cerner: \_\_\_\_\_

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

If yes, explain: \_\_\_\_\_

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

Name of therapy: \_\_\_\_\_ Date last administered: \_\_\_\_\_  None

**NOTE:**

- **Reclast® is not for use in patients already receiving Zometa®, other bisphosphonates, or denosumab products including Prolia®, Xgeva®, or biosimilars**
- **Zoledronic acid is not recommended for use in patients with renal impairment / creatinine clearance less than 35mL/min.**
- **Cockcroft-Gault will be used to determine creatinine clearance.**
- **Pre-existing hypocalcemia and vitamin D deficiency should be corrected prior to initiation of therapy. Calcium and vitamin D supplementation is recommended throughout the duration of therapy with zoledronic acid.**

**Treatment:**

- Zoledronic Acid 5 mg / 100 mL IV over 15 minutes once

**Protocol Orders:**

- Hypersensitivity/Anaphylaxis Medications: Follow Adult Hypersensitivity Nursing Protocol PRN for the treatment of allergic/hypersensitivity reaction.
- Extravasation Management: Follow established protocol for extravasation as needed.
- Port Care and Flush per Nursing Protocol: Single-lumen flush protocol or double-lumen flush protocol as appropriate.

Physician's Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

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