



Conveniently Located in East Syracuse, Onondaga Hill & Auburn

Main Office Phone 315-472-7504

Nurse Navigator Phone 315-506-2469

Main Fax 315-634-5168

Zoledronic Acid (Reclast, Zometa) Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ Height (inches): _____ Weight (lbs): _____

3. Diagnosis:

E83.52 Hypercalcemia

Other ICD-10 Code: _____ Diagnosis description: _____

4. Pre-medications:

Other Pre-medication: _____

No Pre-medications indicated

5. Drug Order:

Drug/Dose/Frequency:

Reclast 5mg IV every 12 months

Zometa 4mg IV every 3-4 weeks

Other: _____

Dental Clearance:

Ok to proceed without dental clearance

Ok to proceed, dental clearance obtained, Date: _____ (copy of clearance attached)

New to Therapy

Continuing therapy: Last Dose Received _____ Next Dose Due _____

- Is the patient on Calcium & Vitamin D replacement? Yes No

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

CMP within 30 days of infusion

Other: _____

No lab monitoring indicated

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.

The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. Required Baseline Lab/Testing have been completed:

CMP, date: _____ Other: _____ None

8. Patient Assistance & REMS Program Enrollment

Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)

No, patient has not been enrolled in any programs.

7. Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

(This drug administration order form is valid for 12 months)

Dental Clearance for Drug Administration

Patient Name: _____ **DOB:** _____

Prescribing MD: _____ **Prescribing MD Phone Number:** _____

The above mentioned patient requires therapy with the following medication, under my supervision:

____ Zometa

____ Xgeva

____ Aredia

____ Reclast

____ Prolia

____ Boniva

____ Evenity

Please evaluate the patient for clearance or any other recommendations following your exam.
The patient may need follow up dental/jaw exams every six months.

Please fax this form back, with your comments, to my office at (fax) _____.

Dental Clearance APPROVED

Dental Clearance DENIED.

See Comments and Recommendation Below:

Treating Dentist: _____

Dentist Signature: _____

Date: _____