ArrIVe INFUSION THERAPY

An Outpatient Department of Trinity Health Oakland
9406 Village Place Blvd, Brighton, MI 48116
Phone: 810-844-7373
Fax: 810-844-7366

Zoledronic Acid (RECLAST ®, ZOMETA ®)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVe Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

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

Patient Name: _____ **Patient Address:** _____ **Patient Phone Number:** _____ **Date of Birth**: ____/____/____ **Weight:** _____kg **Height:** _____cm **Allergies:** _____	**Primary Insurance:** _____ **Member ID:** _____ **Secondary Insurance:** _____ **Member ID:** _____
Diagnosis Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____	**Labs (within 30 days of treatment)** ☐ Albumin ☐ Creatinine, serum ☐ Calcium ☐ Other: _____ **Creatinine Clearance (Cockroft-Gault)** $\frac{(140-\text{Age}) \times \text{Weight(kg)}}{72 \times \text{Serum Creatinine}}$ x *[0.85 if female patient]* **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** in 100 mL 0.9% sodium chloride IVPB over at least 15 minutes	☐ **Zoledronic acid (ZOMETA ®) 4 mg** in 100 mL 0.9% sodium chloride IVPB over at least 15 minutes **Frequency** ☐ Every 3 weeks ☐ Every 4 weeks

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Pre-Medications and Pre-Protocol (ordered at physician discretion)	☐ Acetaminophen 650 mg PO once ☐ Loratadine 10 mg PO once ☐ Diphenhydramine once ☐25 mg ☐50 mg ☐ PO ☐IV ☐ Famotidine 20 mg IV once ☐ Hydrocortisone 100 mg IV once ☐ Methylprednisolone 125 mg IVP once ☐ Other: _____	**Hydration** ☐ LR ☐ Sodium Chloride 0.9% ☐ Other _____ _____ mL at _____mL/hr ☐ Before ☐ During ☐ Following
Flushing Protocol *as needed for line care*	☐**Sodium Chloride 0.9%** ☐5 mL ☐10 mL	☐**Heparin 100 Units/mL** ☐5 mL ☐10 mL
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	• **Sodium chloride** 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • **Acetaminophen** 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • **Albuterol** 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • **Albuterol HFA** inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • **Epinephrine** injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • **Famotidine** injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • **Diphenhydramine** injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • **Diphenhydramine** injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • **Hydrocortisone** sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure	

Provider Name: _____ Provider Signature: _____

Attending Physician Name: _____ Provider NPI: _____

Office Phone Number: _____ Office Fax Number: _____

Note: This order is valid for 12 months from date of physician signature.

Submit