LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order ZOLEDRONIC ACID (ZOMETA)	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (➲) TO BE ACTIVE		

Anticipated Start Date: _____ Patient to follow up with provider on date: _____
*****This plan will expire after 365 days, unless otherwise specified below*****
Orders expire: _____

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis: _____ **Diagnosis Code:** _____

GUIDELINES FOR PRESCRIBING:

1. Send **FACE SHEET, INSURANCE CARD and most recent provider chart or progress note.**
2. This plan should be used in patients with bone lesions associated with multiple myeloma, bone metastases from solid tumors, and hypercalcemia of malignancy.
3. Hypocalcemia must be corrected before initiation of therapy. Patients with multiple myeloma and bone metastases of solid tumors should be prescribed daily calcium and vitamin D supplementation.
4. Risk versus benefit regarding osteonecrosis of the jaw and hip fracture must be discussed prior to treatment.

Dental Clearance: (Must select one)

☐ Dental clearance required prior to initiation (form on page 3) – **Recommended, not required**
☐ Patient may be treated without documentation of dental clearance

PROVIDER TO PHARMACIST COMMUNICATION:

1. Creatinine clearance is calculated using Cockroft-Gault formula (Use actual weight unless patient is greater than 30% over ideal body weight, then use adjusted body weight). If serum creatinine is below 0.7 mg/dL, use 0.7 mg/dL to calculate creatinine clearance. The following dose adjustment instruction applies only to indications other than hypercalcemia. For hypercalcemia indication, the dose should always be 4 mg. Pharmacist should discuss with provider if SCr is > 4.5 mg/dL.

Creatinine Clearance:	Dose of zoledronic acid:
Greater than 60 mL/min	4 mg
50 - 60 ml/min	3.5 mg
40 - 49 ml/min	3.3 mg
30 - 39 ml/min	3.0 mg
<30 mL/min	Pharmacist to discuss dose with provider

LABS:

☐ CMP, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
☐ Labs already drawn. Date: _____

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NURSING ORDERS:

1. TREATMENT PARAMETER – Pharmacist to calculate corrected calcium. Hold and contact provider for corrected calcium less than 8.4 mg/dL.
2. If no results in past 7 days for every 4-week dosing, or past 30 days for every 12- or 26-week dosing, order CMP.
3. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

PRE-HYDRATION:

1. Have patient drink at least 2 glasses of fluid prior to infusion.

MEDICATIONS:

- zoledronic acid (ZOMETA) 4 mg in sodium chloride 0.9%, 100 mL, intravenous, ONCE, over 15 minutes

  Interval: ***(must check one)***
  - ☐ ONCE
  - ☐ Every _____ weeks x _____ doses (minimum of 7 days between doses for hypercalcemia)

NURSING ORDERS (TREATMENT PARAMETERS):

1. Nursing communication order: Encourage good hydration during and after infusion.
2. Nursing communication order: If corrected calcium is between 8.4 and 8.8 review home medication for calcium and vitamin D supplementation. If patient is not on these agents, notify provider
3. Nursing communication order: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters
4. Nursing communication orders: Manage hypersensitivity reactions per LH 906.6606

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Please check the appropriate box for the patient's preferred clinic location:

☐ **Legacy Day Treatment Unit – The Vancouver Clinic Building**
A department of Salmon Creek Medical Center
700 NE 87th Avenue, Suite 360
Vancouver, WA 98664
Phone number: 360-896-7070
Fax number: 360-487-5773

☐ **Legacy Salmon Creek Day Treatment Unit**
Legacy Salmon Creek Medical Center
2121 NE 139th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773

☐ **Legacy Woodburn STEPS Clinic**
A department of Silverton Medical Center
Legacy Woodburn Health Center
1475 Mt Hood Ave
Woodburn, OR 97071
Phone number: 503-982-1280
Fax number: 503-225-8723

☐ **Legacy Emanuel Day Treatment Unit**
A department of Emanuel Medical Center
501 N Graham Street, Suite 540
Portland, OR 97227
Phone number: 503-413-4608
Fax number: 503-413-4887

☐ **Legacy Silverton STEPS Clinic**
Legacy Silverton Medical Center
342 Fairview Street
Silverton, OR 97381
Phone number: 503-873-1670
Fax number: 503-874-2483

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

Organization/Department: _____

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Dental Clearance Letter

Re: _____ DOB:_____

To Whom It May Concern:

Our mutual patient noted above is scheduled to start denosumab or a bisphosphonate medication for the medical treatment of _____.

It has been reported that a small number of patients taking these medications may develop a condition known as osteonecrosis following certain dental treatments. We are requesting a dental clearance prior to the initiation of the medical treatment. Please perform a complete dental evaluation and treat any dental conditions that may lead to future teeth extractions or other invasive dental procedures.

Thank you for your assistance.

_____
Name of referring medical practitioner

Date of last dental exam: _____

☐ Patient is free of active dental infection or need for further dental treatments and is cleared to receive denosumab or a bisphosphonate medication

☐ Patient is NOT cleared to receive denosumab or a bisphosphonate medication

Additional comments:

_____
_____
_____

_____	_____	_____
Printed name of Dentist	Signature of Dentist	Date

Please fill out and fax this letter to the infusion center where patient will receive treatment. Attn: Pharmacist

Fax:_____