LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order ZOLEDRONIC ACID (RECLAST)	**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. Please confirm that patient has had a recent oral examination prior to initiating therapy. Schedule for a dental exam if indicated
3. Hypocalcemia must be corrected before initiation of therapy
4. All patients should be prescribed daily calcium and vitamin D supplementation. Recommended dosing: Osteoporosis-- calcium 1200 mg and vitamin D 400 IU-800 IU daily
5. CMP must be within 30 days of treatment unless otherwise specified. Date drawn: _____

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

MEDICATIONS:

- zoledronic acid (RECLAST) 5 mg/100 ml IV, ONCE, over 15 minutes. Doses must be at least 366 days apart

NURSING ORDERS (TREATMENT PARAMETERS):

1. Nursing order: Review previous serum creatinine (SCr) and previous serum calcium and serum albumin. If no results in past 30 days, order STAT CMP
2. Treatment parameters: Hold and notify MD for serum creatinine greater than 1.5 or CrCl <35 mL/min [Creatinine clearance is calculated using Cockcroft-Gault formula (Use actual weight unless patient is greater than 30% over ideal body weight, then use adjusted body weight). If serum creatinine is <0.8 mg/dl, use 0.8 mg/dl to calculate creatinine clearance]
3. Treatment parameters: Hold and notify MD for corrected calcium less than 8.4
4. Nursing communication order: Encourage good hydration during and after infusion.
5. 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
6. Nursing communication order: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters
7. 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 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 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 Silverton STEPS Clinic**
Legacy Silverton Medical Center
342 Fairview Street
Silverton, OR 97381
Phone number: 503-873-1670
Fax number: 503-874-2483

☐ **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

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:_____