## Legacy Day Treatment Unit Provider’s Orders

**Adult Ambulatory Infusion Order**  
**ZOLEDRONIC ACID (ZOMETA)**

### Patient Information

- **Patient Name:**
- **Date of Birth:**
- **Med. Rec. No (TVC MRN Only):**

### Provider’s Orders

- **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.

<table>
<thead>
<tr>
<th>Creatinine Clearance:</th>
<th>Dose of zoledronic acid:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 60 mL/min</td>
<td>4 mg</td>
</tr>
<tr>
<td>50 - 60 ml/min</td>
<td>3.5 mg</td>
</tr>
<tr>
<td>40 - 49 ml/min</td>
<td>3.3 mg</td>
</tr>
<tr>
<td>30 - 39 ml/min</td>
<td>3.0 mg</td>
</tr>
<tr>
<td>&lt;30 mL/min</td>
<td>Pharmacist to discuss dose with provider</td>
</tr>
</tbody>
</table>

### LABS:

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

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Last updated 2/2024
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.
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

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: ____________________________

Last updated 2/2024
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: ________________________________