Ascension St. Vincent's Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Zoledronic Acid (Reclast) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List: _____

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐ Pathological fracture of neck of femur (hip) ☐ Pathological fracture of other specified part of femur ☐ Paget's Disease ☐ Senile Osteoporosis (men or postmenopausal women) ☐ Glucocorticoid-induced osteoporosis ☐ Prevention of postmenopausal osteoporosis ☐ Osteopenia ☐ Other: _____	☐ M84.459 A ☐ M84.453 A ☐ M88.9 ☐ M81.0 ☐ M81.8 + Z79.52 ☐ M89.9 ☐ M85.80 ☐ Other: _____	☑ J3489	☑ CPT Code: _____

Labs (prior to scheduling infusion)	Other labs:
☑ BMP, Calcium, Creatinine (Hold Reclast if calculated creatinine clearance is < 35ml/min), DEXA Scan, 25-hydroxyvitamin D (level must be >/=20 ng/mL or >/=50 nmol/L)	☐ _____ ☐ _____

Nursing Orders	Pre-medications	
☑ Discharge patient when stable and meets protocol criteria	☑ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
Emergency/Anaphylaxis Order	☐ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☑ Follow standard orders for management of allergies and anaphylaxis reactions	☐ Dexamethasone 20 mg IV, once	☐ Other: _____
	☐ Ondansetron 4 mg IV, once	☐ Other: _____

Medication Orders

	Medication	Route	Dose	Frequency	Select Treatment Type
☑	Zoledronic Acid (Reclast)	IV	5 mg	Once	☐ Every 12 months ☐ Every 24 months ☐ Other: _____

Order Comments: Infuse over at least 15 minutes. Flush IV line with 10 mL NS flush following infusion.

Infusion Center Staff Please fax infusion records or discharge summary to: **Fax Number** _____

Provider Signature		**Date**	
Provider Printed Name			