Zoledronic Acid (RECLAST)

TOTAL INFUSION
human-centered care

6955 Foothill Blvd, Suite 67A, Oakland, CA, 94605
Phone: (510) 878-9528 | Fax: (510) 969-5840 | Email: referrals@totalinfusion.com

Name: _____

DOB: _____ Phone: _____

Gender: ☐ Male ☐ Female

Allergies: _____

DIAGNOSIS (ICD-10 code required):

- ☐ _____ Treatment of Osteoporosis
- ☐ _____ Prevention of Osteoporosis
- ☐ _____ Osteoporosis in Men
- ☐ _____ Glucocorticoid-Induced Osteoporosis
- ☐ _____ Paget's Disease of Bone
- ☐ _____ Other: _____

PROVIDER REMINDERS:

- All orders with a ☑ will be placed unless otherwise noted
- Serum Calcium & CrCl prior to treatment
- Consider calcium and vitamin D supplementation
- Routine oral exam recommended prior to treatment
- Pregnancy testing in all females of reproductive potential prior to each treatment

TREATMENT CRITERIA:

Hold Zoledronic acid (RECLAST) If:

- Temperature **GREATER THAN** 100 degrees F
- Complains of symptoms of acute viral or bacterial illness
- Severe hypersensitivity reaction to Zoledronic acid (RECLAST)
- CrCl less than 35mL/min
- Labs indicate hypocalcemia
- Unable to rule out pregnancy

Nursing Considerations:

- Safe Handling Precautions
- Encourage patient to drink 2 glasses of fluid at least one hour prior to infusion
- Instruct patient to take Acetaminophen (TYLENOL) 650mg every 6 hours for post-infusion-flu-like symptoms 2-3 days following infusion as needed.

Premedications

☑ **Acetaminophen (TYLENOL) 650mg PO,** Once, at least 15 minutes prior to Zoledronic acid (RECLAST) infusion.

☐ **Cetirizine (ZYRTEC) 10mg PO,** Once, at least 15 minutes prior to Zoledronic acid (RECLAST) infusion.

☐ _____

Medications

Patient Weight _____kg **(REQUIRED)**

Infuse **Zoledronic acid (RECLAST)** 5mg/100mL through a vented infusion line over 30 minutes

Frequency:

☑ Annually (a new order is required annually)

☐ _____

Last infusion date if transferring from another facility: _____

☑ **IV LINE CARE** per Nursing Policy

☑ **INFUSION REACTION MEDICATIONS** per Standardized Procedures

Special Instruction(s):

Provider Signature _____ Date _____ Email _____

Printed Name _____ Phone _____ Fax _____

Office Contact _____ Phone _____ Email _____