

Patient Name: _____
DOB: _____

**Provider Orders for:
Zoledronic Acid (Reclast) Infusion
[Treatment of Osteoporosis]**

= *must check off to order* / *automatically initiated unless crossed out*

Date: _____ **Time:** _____ **Weight** _____ **kg** **Height:** _____ **cm** **BSA:** _____

Diagnosis: _____

Tests:

Prior to administration of medication:

Obtain **Serum:** Calcium Albumin Creatinine

Calculate creatinine clearance (CrCl)

Notify provider **IF:**

- serum (or corrected) calcium is less than 8.5 mg/dL **--OR--**
- CrCl is less than 35 mL/min **-- AND-- DO NOT ADMINISTER zoledronic acid (Reclast)**

Confirm patient has no signs/symptoms of osteonecrosis of jaw (jaw pain, swelling, redness, loose teeth or exposed bone).
Do NOT administer within 2 months prior or post invasive dental procedures.

Other Medications: _____

IV Line Patency Maintenance:

- NS IV 250 mL at 30 mL/hr during infusion
- Flush central line with 5 mL heparin 100 units/mL IV

zoledronic acid (Reclast) Treatment Order

Creatinine Clearance (mL/min)	Total Daily Dose	Schedule	Route	Time Frame
35 and Greater	5 mg	Once a year	IV	Infuse over 20 minutes
Less than 35	Not recommended			

Other Orders: _____

_____, RN
(Nurse Signature)
83EZOLRE 03/19

(Authorized Provider Signature)