ISLAND INFUSION CENTER

1015 25th Street Building, Upper Level
Anacortes, WA, 98221

Phone: 360.299.4200
Fax: 360.299.4237

PROVIDER ORDER FORM

Zoledronic Acid Infusions

- Please complete form and fax with latest clinical documentation to 360.299.4237
- Include lab results for serum creatinine and calcium within 30 days prior.
- If the calculated CrCl is < 35 ml/min, medicine will not be administered.

Patient Name (First, Middle, Last): _____ D.O.B. _____

Height: _____ ☐ cm ☐ in Weight:_____ ☐ kg ☐ lbs Allergies: _____

Diagnosis: _____ ICD-10 Code: _____

Pre-auth Done? ☐ Not required ☐ Yes Authorization #: _____ Authorization Dates: _____

Medication Orders:

☐ Zoledronic Acid (Reclast – J3489) 5 mg/100 ml IV over at least 15 minutes x 1 dose.

☐ In case of infusion reaction, orders will be carried out per Island Health Policy unless crossed out.

- Stop infusion, obtain VS and assessment, call Provider.*
- NS 0.9% 1000 ml/hour IV for blood pressure < 100/60.
- O2 per nasal cannula to maintain saturation >92%.
- Diphenhydramine 25 mg IV if patient was premedicated with 25 mg within 2 hours of reaction otherwise 50 mg IV once.
- Methylprednisolone succ. 125 mg IV once.
- Epinephrine 0.3 mg IM for severe reaction (may repeat in 3–5 minutes for continued severe symptoms).

☐ I have confirmed this patient has good dental health or a Dental Clearance letter is attached.

PROVIDER SIGNATURE	DATE
PRINT PROVIDER NAME	*PROVIDER EMERGENCY PHONE #

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