



Trinity Health Muskegon & Shelby Infusion Clinics

Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444

Shelby: 72 S. State St. Shelby, MI 49455

Fax (shared): 231-672-3970

Zoledronic Acid (RECLAST®)

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies

Order Date: ___/___/___ Site of Service: TH Muskegon TH Shelby

Referral Status: New Referral Dose or Frequency Change Renewal

Patient Name: _____ Date of Birth: ___/___/___ Weight: ___kg Height: ___cm Allergies: _____	Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____
<p align="center">Diagnosis</p> Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____	<p align="center">Labs (within 30 days of treatment)</p> <input type="checkbox"/> Albumin <input type="checkbox"/> Creatinine (serum) <input type="checkbox"/> Calcium <input type="checkbox"/> Other: _____
<p align="center">Pre-Medications:</p> No routine pre-medications are routinely given. Pre-medications may be ordered at physician discretion. <input type="checkbox"/> Other: _____	<p align="center">Creatinine Clearance (Cockcroft-Gault)</p> $\frac{(140 - \text{Age}) \times \text{Weight(kg)}}{72 \times \text{Serum Creatinine}} \times [0.85 \text{ if female patient}]$ <p align="center"><i>*Utilize <u>actual</u> body weight for creatinine clearance calculation</i></p>
<p>Note to provider: Patient should receive oral calcium and vitamin D therapy.</p>	
<p>Hold and Notify Physician for: CrCL below 35 ml/min (therapy not recommended); Calcium below 8.4 mg/dL (Calcium supplementation needed prior to treatment)</p>	
<p>Rx Zoledronic acid (RECLAST®) 5 mg/ 100ml IVPB over at least 15 minutes</p> <p>Nursing Orders</p> Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary: sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN	
Provider Name: _____ Office Phone Number: _____ Attending Physician Name: _____ <i>(If ordering provider is an advanced practice practitioner)</i> <i>Note: This order is valid for 12 months from date of physician signature.</i>	Provider Signature: _____ Office Fax Number: _____