Corewell Health™

Patient Name	
DOB	
MRN	
Physician	
CSN	

Physician's Orders
ZOLEDRONIC ACID (RECLAST) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER
Page 1 to 3

Corewell Health Site of Service (select one):

☐ **Blodgett Hospital**
1840 Wealthy St. NE
Grand Rapids, MI 49506
Phone: 616.391.0351
Fax: 616.391.8969

☐ **Gerber Hospital**
230 West Oak St.
Fremont, MI 49412
Phone: 231.924.1305
Fax: 231.924.1798

☐ **Greenville Hospital**
615 S. Bower St.
Greenville, MI 48838
Phone: 616.225.9330
Fax: 616.754.4043

☐ **Helen DeVos Children's Hospital**
100 Michigan St. NE
Grand Rapids, MI 49503
Phone: 616.267.1925
Fax: 616.267.1005

☐ **Lemmen Holton Cancer Pavilion** 145 Michigan St. NE
Grand Rapids, MI 49503
Phone: 616.486.6099
Fax: 616.486.6415

☐ **Ludington Hospital**
1 Atkinson Dr.
Ludington, MI 49431
Phone: 231.845.5085
Fax: 231.845.5025

☐ **Neuro Infusion ICCB**
2750 E Beltline Ave NE
Grand Rapids, MI 49525
Phone: 616.391.0351
Fax: 616.391.8669

☐ **Pennock Hospital**
1009 W. Green St.
Hastings, MI 49058
Phone: 269.798.6762
Fax: 269.798.6763

☐ **Reed City Hospital**
4499 220th Ave.
Reed City, MI 49677
Phone: 231.832.7105
Fax: 231.832.0915

☐ **Zeeland Hospital**
8333 Felch St.
Zeeland, MI 49464
Phone: 616.748.3640
Fax: 616.748.3690

☐ **Brownstown Infusion Clinic**
19725 Allen Rd. Suite 101
Brownstown Twp, MI 48183
Phone: 734.479.2371
Fax: 734.479.2451

☐ **Dearborn Hospital**
18101 Oakwood Blvd.
Dearborn, MI 48124
Phone: 313.593.5913
Fax: 313.593.8551

☐ **Farmington Hills Hospital Botsford**
28050 Grand River Ave.
Farmington Hills, MI 48336
Phone: 947.521.8174
Fax: 248.471.8217

☐ **Grosse Pointe Infusion Clinic**
21400 E 11 Mile Rd.
Saint Clair Shores, MI 48081
Phone: 586.498.4498
Fax: 586.498.4497

☐ **Lenox Infusion Clinic**
36555 6 Mile Rd.
Lenox, MI 48048
Phone: 947.523.4060
Fax: 947.523.4061

☐ **Livonia Infusion Clinic**
39000 7 Mile Rd. Suite 1000
Livonia, MI 48152
Phone: 947.523.4360
Fax: 734.542.3356

☐ **Royal Oak**
3601 W 13 Mile Rd.
Royal Oak, MI 48073
Phone: 248.898.1000
Fax: 248.551.3168

☐ **Troy Hospital**
44344 Dequindre Rd. Suite 230
Sterling Heights, MI 48314
Phone: 248.964.3080
Fax: 248.964.2409

☐ **Wayne Hospital**
33155 Annapolis St.
Wayne, MI 48184
Phone: 734.467.2556
Fax: 734.467.2505

☐ **Marie Yeager Cancer Center**
3900 Hollywood Rd.
Saint Joseph, MI 49085
Phone: 269.556.7180
Fax: 269.556.7185

☐ **Niles Infusion**
42 N St Joseph Ave Ste 303
Niles, MI 49120
Phone: 269.684.6140
Fax: 269.683.8744

☐ **Watervliet Hospital**
400 Medical Park Dr.
Watervliet, MI 49098
Phone: 269.463.2310
Fax: 269.463.0012

PATIENT INFORMATION:

Name: First _____ Middle _____ Last _____

Date of birth _____ Phone (_____) _____

Address _____

City _____ State _____ Zip code _____

REFERRAL: Infusion Therapy

Referring Physician (print) _____

Office: Phone (_____) _____ Fax (_____) _____

Direct line for urgent questions about patient (_____) _____

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NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

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Infusions

Anticipated Infusion Date: _____ **ICD-10 Code with Description: _____**

Height _____ (cm) Weight _____ (kg) Allergies _____

Labs to be collected

☒ Comprehensive Metabolic Panel (CMP)
- ☒ Once
- ☐ _____

☐ Magnesium, Blood Level
- ☐ Once
- ☐ _____

☐ Phosphorus, Blood Level
- ☐ Once
- ☐ _____

☐ Additional lab order(s) _____
- ☐ Once
- ☐ _____

Treatment

Frequency:
- ☐ Once

Duration:
- ☐ 1 year
- ☐ # of treatments _____
- ☐ Until date: _____

☒ Zoledronic Acid (RECLAST) 5mg IVPB
Administer over 30 minutes

Supportive Care

☒ Acetaminophen (TYLENOL) 650 mg, PO Once PRN
To reduce the incidence of acute reaction. Acetaminophen after the infusion may reduce the incidence of acute reaction (eg, arthralgia, fever, flu-like symptoms, myalgia).

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ZOLEDRONIC ACID (RECLAST) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

Supplemental Orders

*****The following orders will be applied to the patient's plan unless otherwise indicated*****

Appointment Requests

☒ **Infusion Appointment Request**
Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion and possible labs.

Safety Parameters and Special Instructions

☒ **ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 1**
Renal function (serum creatinine) and serum calcium must be resulted within 3 months of administration.

☒ **ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 4**
ZOLEDRONIC ACID (RECLAST):
Acetaminophen after the infusion may reduce symptoms of acute-phase reactions.
Patients with osteoporosis should receive calcium and vitamin D supplementation if dietary intake is inadequate.
Prior to each dose, obtain serum creatinine and calculate the creatinine clearance using the Cockcroft-Gault formula.
Zoledronic acid is not recommended for patients with severe renal impairment. Longer infusions may reduce risk of nephrotoxicity.

Treatment Parameters

☒ **ONC MONITORING AND HOLD PARAMETERS 15**
Hold treatment and contact provider if serum creatinine greater than 2 mg/dL

☒ **ONC MONITORING AND HOLD PARAMETERS 14**
Hold treatment and contact provider if creatinine clearance (CRCL) less than 35 mL/minute. Zoledronic acid (RECLAST) is contraindicated in patients with creatinine clearance less than 35 mL/min and in those with evidence of acute renal impairment.

☒ **ONC MONITORING AND HOLD PARAMETERS 3**
May proceed with treatment if the patient does not report any symptoms of jaw or dental pain.

☒ **ONC MONITORING AND HOLD PARAMETERS 2**
May proceed with treatment if calcium level is above the lower limit of normal.

Nursing Orders

☒ **ONC NURSING COMMUNICATION 9**
Check that labs indicated for THIS Treatment Cycle have been drawn within the last 3 months or draw them in clinic prior to beginning treatment.

☒ **ONC NURSING COMMUNICATION 200**
May Initiate IV Catheter Patency Adult Protocol

☒ **Hypersensitivity Reaction Adult Oncology Protocol**
Until discontinued Starting when released Until Specified

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED:		**VALIDATED:**		**ORDERED:**			
TIME	**DATE**	**TIME**	**DATE**	**TIME**	**DATE**	Pager #	
	Sign		**R.N. Sign**		**Physician Print**		**Physician Sign**

EPIC VERSION DATE: 12/8/23

