vitalcare of CENTRAL MISSISSIPPI

Fountains Infusion Center

159 Fountains Blvd. Madison, MS 39110 Phone:
601.859.8200 Fax: 601.859.8201

ZOLEDRONIC ACID INFUSION ORDERS

REQUIRED INFORMATION

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ Dexa Scan (-2.5 T score or more severe)
  ***if no -2.5 T score, please send history of fracture documentation*
- ☐ Documentation to support primary diagnosis
  (Clinical/progress notes, other medications tried & failed, labs, diagnostic tests, etc.)
- ☐ **Required Labs:** CMP/BMP within the last 30 days, **CrCL must be >35ml/min**

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis ICD-10: ☐ Senile Osteoporosis (ICD-10: ____)

Other__________________ (ICD-10: ____)

J Code:J3489

Zoledronic Acid Orders

Patient Wt.____________kg

*Patient is currently taking calcium/vitamin D supplementation ☐YES ☐NO

☐ Zoledronic Acid 5mg/100mL IV over 30 minutes once yearly

Sodium Chloride 250mL IV prior to AND post infusion of Zoledronic Acid

Pre-Medication Orders: Tylenol 650mg PO, please choose one antihistamine:

- ☐Cetirizine 10mg PO
- ☐Diphenhydramine 25mg PO
- ☐Loratadine 10mg PO

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

Lab orders: CMP/BMP to be drawn within 30 days prior to infusion

Patient MUST have a calculated creatinine clearance of at least 35 ml/min and a normal serum calcium level

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	