MIC METRO INFUSION CENTER

# Zoledronic Acid (Zometa)

Name: _____
DOB: _____
Diagnosis/Code: _____/_____
Cancer Stage: _____

**Dose calculation:**
Flat dose, not a weight based medication

**Dosing Guidelines/Parameters:** ***Provider must select hold parameters that will trigger a call from the Infusion Staff***

☐ Dental clearance done (send clearance or note that outlines no dental issues)

☐ Creatinine clearance-based dosing (Referring office will get labs prior to each infusion and send labs to MIC **with creatinine clearance** listed to determine dosing)

☐ Calcium WNL

**Hydration Orders:**

☐ Not required ☐ Other:

**Premedication Orders:**

_____

**Treatment Orders:**

| DRUG | DOSE | ROUTE | DAYS TO BE GIVEN |
|---|---|---|---|
| ☐ Zoledronic Acid (Zometa ) | 4mg*<br>Creatinine Clearance >60 | IVPB | Every 4 weeks<br>Every 3 months<br>Every _____ |
| ☐ Zoledronic Acid (Zometa ) | 3.5mg*<br>Creatinine Clearance 50-60 | IVPB | Every 4 weeks<br>Every 3 months<br>Every _____ |
| ☐ Zoledronic Acid (Zometa ) | 3.3mg*<br>Creatinine Clearance 40-49 | IVPB | Every 4 weeks<br>Every 3 months<br>Every _____ |
| ☐ Zoledronic Acid (Zometa ) | 3mg*<br>Creatinine Clearance 30-39 | IVPB | Every 4 weeks<br>Every 3 months<br>Every _____ |
| | | | |

***Provider to send new order if Creatinine Clearance changes from original order.**

Date of intended first treatment at Metro Infusion Center:_____

Subsequent treatment may be given +/- 2 days or as otherwise specified:

***This order is good for 1 year from the date ordered***

Other:

Call referring provider for:

Date:

Referring Provider:_____ _____ Phone# _____
SIGNATURE REQUIRED PRINTED NAME REQUIRED

**Office Contact name/number:**

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email: Intake@metroinfusioncenter.com or fax to (866)507-1164

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