

Height _____ Weight ____

Riverbend Medical Center Regional Infusion Center (RIC) 3377 Riverbend Drive Suite 502/510 Springfield, Oregon 97477 Phone 541-222-6280 Fax 541-349-8006

Zoledronic acid (Reclast) Order Set (v. 05/24/2024)

Diagnosi	sis/Indication (ICD-10):	
*Patient must	t have creatinine, calcium, and vitamin D labs done within 9	0 days
Medications	is:	
	Zoledronic acid 5 mg/ 100 mL IVPB over 15 minutes every 12 months	
Nursing con	mmunications:	
	Vital signs: as needed during infusion	
	Hold treatment for patients with creatinine clearance less than 35 mL/ $_{\rm I}$	nin or calcium less than normal range
Access:		
	Insert peripheral IV - Every visit, remove after IV administration complete	
	Access & Use Central Line / CVAD - Initiate Central Line (Non-PICC) Maintenance Protocol - Heparin, porcine (PF) 100 unit/mL flush 5 mL as needed for - Alteplase (Cathflo) 2 mg as needed for occluded catheter. It to 2 hours, instill a 2nd dose if occluded	Port-a-Cath line care for clearing central line catheter- retain in catheter for 30 minutes
÷	Access & Use PICC Initiate PICC Maintenance Protocol Normal saline flush 3 mL as needed for PICC/ Hickman line Alteplase (Cathflo) 2 mg as needed for occluded catheter. I hours, instill a 2nd dose if occluded	care for clearing central line catheter- retain in catheter for 30 minutes to 2
n diapho A n mild to 20 po Conta	noresis, fever, palpitations, chest discomfort, blood pressure change Administer 25 mg IV once, if reaction does not resolve in 3 minutes MethylPREDNISolone sodium succinate (Solu-MEDROL) 125 to moderate drug reaction (flushing, dizziness, headaches, diaphooints in SBP), nausea, urticaria, chills, pruritic) that worsen or pact provider if given.	may repeat 25 mg IV dose for a total of 50 mg and contact provider. mg IV once as needed for shortness of breath, continued symptoms of resis, fever, palpitations, chest discomfort, blood pressure changes (>/= ersist 5 minutes after administration of diphenhydramine (Benadryl). not resolve in 3 minutes may repeat 0.3 mg IM dose for a total of 0.6 m usive vascular disease. Contact provider if given.
Patient name: _ DOB: _		ovider printed name:ovider signature:

Date: ______ Time: _____