St. Clair Hospital
Pittsburgh, PA 15243

Zoledronic Acid (Reclast)
PHYSICIAN ORDER SET

Patient Name: _____ Date of birth: _____

Allergies: _____ Weight: _____lbs _____kg

Diagnosis_____ Height: _____ft _____in

ICD-10 Code: _____ Additional applicable ICD-10 Code(s) _____

Ordering Physician Name (***Print***): _____

Date of last Zoledronic Acid (Reclast) administration:_____ : ☐ N/A (Initial dose ordered)
(Please attach supporting documentation) Month /Day / Year

Laboratory Documentation Required* (if performed at non-St.Clair Laboratory, attach copy of results):

Serum Creatinine: _____ mg/dL on _____ (date)

Calcium Level: _____ mg/dL on _____ (date)

Normal Serum Calcium Level: ☐ Yes ☐ No

**Lab results cannot be older than 1 month*

Calculated Creatinine Clearance ≥35 *mL*/min: ☐ Yes ☐ No

Criteria for administration (must be documented):

- Must have post menopausal osteoporosis or osteopenia
- T-score of < -2.5 **or**
- If T-score is between negative 1.5 and negative 2.5, documented compression fractures of axial skeleton or peripheral fractures
- Please check with insurance company to verify if authorization is required

If using for Paget's Disease, all laboratory tests as above are required PLUS:

- Documentation of serum alkaline phosphatase ≥2 times upper limits of normal for age-specific normal reference (or symptomatic)

Zoledronic acid (Reclast) TREATMENT ORDER

Drug	*Total Dose*	*Route/Duration*	*Schedule*
Zoledronic acid (Reclast)	5 mg	IV over 30 minutes	x1 dose per year

Also required from physician office:

- History and Physical *or* Assessment and Plan, *or* Physician Office Progress Notes
- Insurance Authorization

Authorization # and Dates (*from and to*): _____

Physician Signature:_____ Date: _____ Time: _____

Physician Office Phone: _____Fax: _____

Fax order and medical record documentation to (412) 942-3559