KAISER PERMANENTE®

Zoledronic Acid (ZOMETA)
Infusion Therapy Plan Orders

Name: ________________________________

Kaiser Permanente Member I.D. # ______________

Date of Birth ____________________________

Instructions to Provider

Review orders and note any changes. All orders with ☑ will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers at the end of this protocol).
Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.

Please complete all of the following:

Order Date: ____________ **Weight:** ________kg	**Diagnosis:** ICD-10 code *(REQUIRED):* ________________ ICD-10 description____ ____

General Plan Communication

- Special instructions/notes: ____

Provider Information

- Osteonecrosis of the jaw precautions/patient counseling.
- Consider daily supplementation with at least oral calcium 500 mg and vitamin D 400 international units unless patient has hypercalcemia.
- Consider Zoledronic acid every 12 weeks for bone metastasis.
- NATIONAL ONCOLOGY DRUG TREATMENT PATHWAY: MULTIPLE MYELOMA SUPPORTIVE THERAPY, Pathway Pearl:
  For patients with bone involvement or osteoporosis, zoledronic acid monthly is advised. For patients achieving a CR or VGPR or those with mild bone involvement at diagnosis, zoledronic acid may be given every 3 months. For patients with well controlled myeloma bisphosphonates can be stopped after 1 - 2 years and restarted if new bone disease develops.

Infusion Therapy

☐ **Zoledronic acid (ZOMETA) in 0.9% sodium chloride 100 mL IV infusion**

Dose: ☐ **4 mg** ☐ **_______ mg**

Route: Intravenous

Frequency: ☐ Every 4 weeks ☐ Every 12 weeks ☐ Every ______ weeks

Infusion Rate: ☑ Over 30 minutes.

Note any changes to above regimen: ____

Note Usual initial doses:

4.0 mg if creatinine clearance is greater than 60 mL/min
3.5 mg if creatinine clearance is 50 to 60 mL/min
3.3 mg if creatinine clearance is 40 to 49 mL/min
3.0 mg if creatinine clearance is 30 to 39 mL/min

Pre-Meds

☐ Other: ______________________________

Dose: _______ *Route:* *Frequency:*

☑ No pre-medications necessary. Contact provider if patient has reaction and requires pre-medications for future doses.

IV Line Care

☑ 0.9% sodium chloride infusion 250 mL

Rate: 30 mL/hr *Route:* Intravenous *Frequency:* Run continuously to keep vein open

Start peripheral IV if no central line

Provider Signature: ____ **Date:** _______________

Printed Name: ______________________________________ **Phone:** ___________ **Fax:** ___________

Name: ______________________________

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Zoledronic Acid (ZOMETA)

Infusion Therapy Plan Orders

Lab Review for Nursing

Baseline Labs(one time draw, prior to first infusion): SCr, Ca, 25-Hydroxy Vitamin D level, Serum Albumin
Labs Before Treatment (within 14 days of planned treatment day): SCr, Ca, Serum Albumin

Lab Parameters to Assess:

- CrCl greater than 60 mL/min.
- For patient with BASELINE SCR LESS THAN 1.4 mg/dL, notify provider if there is an increase in SCr from baseline of less than or equal to 0.5 mg/dL.
- For patient with BASELINE SCR GREATER THAN OR EQUAL TO 1.4 mg/dL, notify provider if there is an increase in SCr from baseline of less than or equal to 1 mg/dL.

Infusion Reaction Meds

☑ albuterol (PROVENTIL) nebulizer solution 0.083%
Dose: 2.5 mg Route: Nebulization Frequency: PRN for shortness of breath/wheezing

☑ diphenhydrAMINE (BENADRYL) injectable
Dose: 25 mg Route: Intravenous Frequency: Once PRN, May repeat x1 for urticaria, pruritus, shortness of breath. May repeat in 15 minutes if symptoms not resolved.

☑ EPINEPHrine (Epi-Pen) 0.3 mg/0.3 mL IM Auto-Injector
Dose: 0.3 mg Route: Intramuscular Frequency: Once PRN for anaphylaxis. Inject into lateral thigh and hold area. Use for patients weighing greater than 27.3 kg (60 lbs). Use amp and 1.5 inch needle for patients with BMI greater than 30. Notify physician if administered.

☑ MethylPREDNISolone Sod Succ (PF) Inj 125 mg (SOLU-Medrol PF).
Dose: 125 mg Route: IV push Frequency: Once PRN for hypersensitivity reaction. Notify MD upon giving medication.

Nursing Orders

- Confirm patient is taking oral calcium and vitamin D supplements if ordered.
- Discontinue IV line when therapy complete and patient stabilized.

References

Himelstein AL, et al. JAMA. 2017 Jan 3;317(1):48-58.
Anderson K, et al. J Clin Oncol. 2018 Mar 10;36(8):812-818
Rosen LS, Gordon D, Kaminski M, et al. Cancer Journal, 2001;7:377-387
Zoledronic Acid package insert
Brufsky AM, et al. J Clin Oncol. 2007; 25:829-836.
Dhesy-Thind S, et al. J Clin Oncol. 2017 Jun 20;35(18):2062-2081

Kaiser Permanente Infusion Locations

Bellevue Medical Center
11511 NE 10th St, Bellevue, WA 98004
Fax: 425-502-3811 Phone: 425-502-3820

Capitol Hill Medical Center
201 16th Ave E, Seattle WA 98112
Fax: 206-326-3624 Phone: 206-326-3180

Everett Medical Center
2930 Maple St, Everett, WA 98201
Fax: 425-261-1578 Phone: 425-261-1566

Olympia Medical Center
700 Lilly Road N.E., Olympia, WA 98506
Fax: 360-923-7609 Phone: 360-923-7600

Riverfront Medical Center – Spokane
W 322 North River Drive, Spokane, WA 99201
Fax: 509-434-3184 Phone: 509-324-6464

Silverdale Medical Center
10452 Silverdale Way NW, Silverdale, WA 98383
Fax: 360-307-7421 Phone: 360-307-7316

Tacoma Medical Center
209 Martin Luther King Jr Way, Tacoma, WA 98405
Fax: 253-596-3351 Phone: 253-596-3350

Provider Signature: ______________________ **Date:** __________

Printed Name: ______________________ **Phone:** __________ **Fax:** __________