Zoledronic acid

Provider Order Form

Newport Superior Infusion
1501 Superior Ave, Suite 202
Newport Beach, CA 92663
Phone: 949-601-6001
Fax: 866-542-8631

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight lbs / kg: Height in / cm:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☐ Provide nursing care per Newport Infusion Standard Procedures

☐ Hepatitis B status and date (list results and attach clinicals): _____

RECOMMENDED PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) 125mg IV

PRE-MEDICATION ORDERS

☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ famotidine (Pepcid) 20mg PO
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every_____
☐ CMP ☐ at each dose ☐ every_____
☐ CRP ☐ at each dose ☐ every_____
☐ Other:
_____

THERAPY ADMINISTRATION

☑ Zoledronic acid

- Dose
  - ☐ 5mg IV
  - ☐ 4mg IV
  - ☐ Other: _____
- Frequency
  - ☐ Every 3 weeks
  - ☐ Every 4 weeks
  - ☐ Every 6 months
  - ☐ Every 12 months
  - ☐ Other: _____
- Rate
  - ☐ Infuse over 15 min
  - ☐ Other: _____
- Quantity
  - ☐ 1 Vial
  - ☐ Other: _____

Refills: ☐ Zero / ☐ for 12 months
☐ _____ (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Date**

Provider Signature