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PAMIDRONATE DISODIUM ORDER FORM

2026: \$279 Administration Fee Plus Medication (In House Pharmacist)

Patient

Name: _____ DOB: _____ (dd,mmm,yyyy) Weight: _____

Address: _____ Height: _____ Weight: _____

Phone: _____ City and Postal Code: _____

Email: _____

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ (dd,mmm,yyyy) any reactions? _____

Diagnosis

Allergies: _____

Most recent serum calcium level _____ serum creatine _____ date _____

Medication Orders

- ☐ Pamidronate 30mg IV in 500cc NS over 4 hours every _____
- ☐ Pamidronate 60mg IV in 500cc NS over 4 hours every _____ (CRPS recommended dose)
- ☐ Pamidronate 90mg IV in 500cc NS every _____
- ☐ Pamidronate _____ mg IV over _____ hours every _____

Premedication Orders

- ☐ Acetaminophen 650mg PO prior to infusion
- ☐ Diphenhydramine 25mg PO prior to infusion
- ☐ Other: _____
- ☐ Other: _____

Emergency Medications

Administer the following medications as needed for infusion-related reactions per Solis medical Clinic IV therapy protocol

Adults (weight>40kg):

Diphenhydramine 25mg-50mg PO -----

Diphenhydramine 25mg-50mg slow IV push over 2-5 mins -----

Acetaminophen 325mg-650mg PO _____

Methylprednisolone 125mg

Epinephrine 0.3mg IM/SQ, may repeat x1 _____

Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive _____

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100%

Prescriber Information

Prescriber Name: _____ PRAC ID # _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

Please fax the completed form to 587-805-2539