**PROTOCOL CODE: BRAJZOL2**

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht_________ cm  Wt_________ kg  BSA_________m²</th>
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**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

**DATE:**

**To be given:**

**Cycle(s) #:**

Date of Previous Treatment:

- Delay treatment ________ week(s)
- Creatinine day of treatment

May proceed with doses as written if within 28 days Creatinine Clearance greater than or equal to 60 mL/min.

Dose modification for:
- Renal Function
- Other Toxicity

Proceed with treatment based on blood work from ____________________________________________

**TREATMENT:**

- zoledronic acid 4 mg

  - Dose Modification*: 3.5 mg OR 3.3 mg OR 3 mg (circle one)

  - IV in 100 mL NS over 15 min every 3 months x _______ treatments.

  * see protocol for dose modification guidelines for renal insufficiency

**RETURN APPOINTMENT ORDERS**

- Return in three or ______ months (circle one) for doctor and treatment.
- Book Daycare or chemo room (circle one) x one or three treatments (circle one)

Every treatment: **Serum Creatinine**

If clinically indicated: □ Serum Calcium  □ Albumin

□ Other tests:

□ Consults:

□ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**