AN OUTPATIENT MEDICAL CENTER SPECIALIZING IN
INFUSION AND NON-NARCOTIC INJECTABLE MEDICATIONS

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Zoledronic Acid (Reclast®) Orders

Required Information to accept this order/referral:

- ❑ This signed order form from ordering provider
- ❑ Patient demographics and insurance information
- ❑ Copy of insurance cards, front and back
- ❑ DEXA scan (-2.5T score or greater)
- ❑ Calcium **and** creatinine level within 30 days of treatment
- ❑ Documentation to support primary diagnosis *(Clinic Notes, fracture history, medications tried/failed, labs, diagnostic tests, etc..)*

Patient Name: ______________________________ **DOB:** ______________

Phone: ______________________ **Allergies:** ______________________

Height: ________ **ft** ________ **in** **Weight:** ____________ **lb / kg (circle one)**

Diagnosis/ICD10:

❑ M81.0 (Age-related osteoporosis without current pathological fracture)

❑ M80.0_____ (Age-related osteoporosis with current pathological fracture)
Please provide complete code in the blank above to specify site and encounter type

❑ Other:____
Please specify ICD-10 code and description

Patient Medical Information:

Prior osteoporosis therapies and reason for discontinuing:

____

Patient is currently taking calcium and vitamin D supplements ❑ Yes ❑ No

Patient has history of osteoporotic fracture ❑ Yes** ❑ No

***if yes, please provide documentation of fracture*

Prescription:

Obtain IV Access. Administer Zoledronic Acid (Reclast®) 5mg/100ml IV over no less than 15 minutes x1.

Optional pre-medications:

❑ Administer Tylenol PO 1000mg

Ordering Provider Information

Name ______________________________

Address ______________________________

____

NPI # ______________________________

Signed ______________________________

Office Contact Information

Name ______________________________

Phone ( ) ________-____________

Fax ( ) ________-____________

Email ______________________________

Date ________ / ________ / ____________
MM DD YYYY