

Reclast® (zoledronic acid) Order Form

Please include the following (required):

1. Patient Demographics & Insurance Information
2. DEXA Scan (-2.5 T score or more severe) **if no -2.5 T score, please send history of fracture documentation
3. Documentation to support primary diagnosis (Clinical/progress notes, labs, diagnostic tests, etc.)

Patient Name **DOB**

Allergies **Weight** **Patient Phone**

Primary Diagnosis (Must include ICD-10 code)

- Senile Osteoporosis ICD-10 code: _____
- Paget's Disease of Bone ICD-10 code: _____
- Glucocorticoid-induced Osteoporosis ICD-10 code: _____

Prescription Orders: Reclast® 5mg/100ml (zoledronic acid)

Hypocalcemia must be corrected prior to beginning Reclast and the referring Physician will continue monitor patient for hypocalcemia.

Infuse by peripheral IV over 30 minutes once a year.

Premeds: Acetaminophen 650 mg PO Other _____

***Please check to confirm the following (REQUIRED):**

- Calcium Level ≥ 8.3 within 90 days prior to infusion.
- Creatinine Clearance ≥ 35 ml/min within 90 days prior to infusion.

Provider Name **Phone** **Fax**

Provider's signature **Date**

**Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5644.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com**