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MMI

# Reclast® (zoledronic acid) ORDER FORM

**Date:** ____________________

## PATIENT INFORMATION

| Name: | Phone: | DOB: SEX: M ☐ F ☐ |
|---|---|---|
| ☐ NKDA Allergies: | | Weight lbs/kg: |

## PHYSICIAN INFORMATION

| Physician Name*: | NPI: | |
|---|---|---|
| Address: | Office Contact Name: | Office Contact #: |
| Phone: Fax: | Email (for updates): | |

## REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

RECLAST: commonly used to treat various bone conditions, particularly osteoporosis:
- ☐ Treatment to increase bone mass in men with osteoporosis
- ☐ Treatment and prevention of glucocorticoid-induced osteoporosis
- ☐ Treatment of Paget's disease of bone in men and women
- ☐ Treatment and prevention of postmenopausal osteoporosis

## DIAGNOSIS *Please provide ICD-10 code*

- ☐ M81.0
- ☐ ________

## PRE-MEDICATION

- ☐ Tylenol PO 650mg ☐ 1000 MG ☐ other ______________
- ☐ Solumedrol 125mg IV ☐ other ___________
- ☐ Benadryl ☐ 25mg ☐ 50mg ☐ other _________ ☐ IV ☐ PO
- ☐ Medication ________ Dose _______ Route _______
- ☐ ________________________ *(other)* ☐ ________________________ *(other)*

## CONTRAINDICATIONS

- ☐ Hypocalcemia
- ☐ Patients with creatinine clearance less than 35 mL/min and in those with evidence of acute renal impairment
- ☐ Hypersensitivity to any component of Reclast

## NOTE:

## WARNINGS AND PRECAUTIONS

**Patients receiving Zometa should not receive Reclast**

## RECLAST ORDERS

**PATIENT WEIGHT**

__________ lbs.
__________ kg

**DOSAGE**

- ☐ 5 mg in a 100 ml ready-to-infuse solution
- ☐ Other__________________________

**FREQUENCY**

- ☐ Once
- ☐ Other__________________________

Date of last dose:_____________________________

## REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Recent labs to include **CMP,** within 3 months
_____ Dexa Scan, 2 Years
_____ Current Medication List
_____ Progress Notes

**ORDERING PROVIDER**

Signature **X** ______________________________ Date ______________ **NPI**________________

Provider ______________________ Phone ________ Fax ______________