

Connecticut  
500 W Putnam Ave  
Ste 435  
Greenwich, CT 06830



# Reclast® (zoledronic acid)

ORDER FORM

Date: \_\_\_\_\_

## PATIENT INFORMATION

Name:	Phone:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
<input type="checkbox"/> 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 \_\_\_\_\_