Hackensack
385 Prospect Avenue
Suite 101
Hackensack, NJ, 07601

Marlton
127 Church Road
Suite 203
Marlton, NJ 08053

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Long Branch
422 Morris Avenue
Suite 7
Long branch, NJ 07740

Somerset
81 Veronica Avenue
Suite 202
Somerset NJ 08873

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 _____