

TN  
100 Covey Drive  
Suite 307  
Franklin, TN 37067



# 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			
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order			
<p><b>RECLAST:</b> commonly used to treat various bone conditions, particularly osteoporosis:</p> <input type="checkbox"/> Treatment to increase bone mass in men with osteoporosis <input type="checkbox"/> Treatment and prevention of glucocorticoid-induced osteoporosis <input type="checkbox"/> Treatment of Paget's disease of bone in men and women <input type="checkbox"/> Treatment and prevention of postmenopausal osteoporosis			
<p><b>DIAGNOSIS</b> <i>Please provide ICD-10 code</i></p> <input type="checkbox"/> M81.0 <input type="checkbox"/> _____ <p><b>PRE-MEDICATION</b></p> <input type="checkbox"/> Tylenol PO 650mg <input type="checkbox"/> 1000 MG <input type="checkbox"/> other _____ <input type="checkbox"/> Solumedrol 125mg IV <input type="checkbox"/> other _____ <input type="checkbox"/> Benadryl <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> other _____ <input type="checkbox"/> IV <input type="checkbox"/> PO <input type="checkbox"/> Medication _____ Dose _____ Route _____ <input type="checkbox"/> _____ (other) <input type="checkbox"/> _____ (other) <p><b>CONTRAINDICATIONS</b></p> <input type="checkbox"/> Hypocalcemia <input type="checkbox"/> Patients with creatinine clearance less than 35 mL/min and in those with evidence of acute renal impairment <input type="checkbox"/> Hypersensitivity to any component of Reclast	<p><b>RECLAST ORDERS</b></p> <p><b>PATIENT WEIGHT</b></p> _____ lbs. _____ kg <p><b>DOSAGE</b></p> <input type="checkbox"/> 5 mg in a 100 ml ready-to-infuse solution <input type="checkbox"/> Other _____ <p><b>FREQUENCY</b></p> <input type="checkbox"/> Once <input type="checkbox"/> Other _____ <p>Date of last dose: _____</p>		
<p><b>NOTE:</b></p>   	<p><b>REQUIRED DOCUMENTATION CHECKLIST:</b></p> _____ Patient Demographics _____ Insurance Card/Information _____ Recent labs to include <b>CMP</b> , within 3 months _____ DEXA Scan, 2 Years _____ Current Medication List _____ Progress Notes		
<p><b>WARNINGS AND PRECAUTIONS</b>  <small>Patients receiving Zometa should not receive Reclast</small></p>			

**ORDERING PROVIDER**

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

NPI \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_