NORTH TEXAS INFUSION CENTERS

Reclast® (zoledronic acid) Order Form

Please include the following (<u>required</u>):
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 (<u>Must include ICD-10 code</u>)
☐ Senile Osteoporosis ICD-10 code: _____
☐ Paget's Disease of Bone ICD-10 code: _____
☐ Glucocorticoid-induced Osteoporosis ICD-10 code: _____

<u>Prescription Orders: Reclast® 5mg/100ml (zoledronic acid)</u>
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.

<u>Premeds:</u> ☐ Acetaminophen 650 mg PO ☐ Other _____

***Please check to confirm the following (<u>REQUIRED</u>):**
☐ Calcium Level <u>≥</u>8.3 within 90 days prior to infusion.
☐ Creatinine Clearance <u>≥</u> 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