USE BALL POINT PEN ONLY

Fax the following information to:
- **SPU @ (336) 629-8844**

Randolph Health Order Form: Zoledronic Acid (Reclast®)

➢ **Pt. Name : *Last First Middle***	➢ **Pt. D.O.B.**	
Pt. Phone #:	Pt. Sex M or H	

- ➢ Most recent office note
- ➢ Medication List
- ➢ Completed Reclast® Order Form (this form)
- ➢ Copies of required labs (see below for requirement)

If Brand Name Reclast® is indicated, the following information is needed in addition to the above:

✱ Summary of Benefits (for Brand name Reclast® only) ✱ Pre-authorization (if needed)

*****Please do not fax referral until you have all required information*****

CLINICAL INFORMATION AND PATIENT EDUCATION:

**** All requirements below must be completed and the corresponding box MUST be checked before Zoledronic Acid (Reclast®) infusion can be scheduled. ****

1. Date of last Zoledronic Acid (Reclast®) infusion _____(must be at least 366 days prior to this infusion)
   - ☐ NO prior Zoledronic Acid (Reclast®) infusions (first treatment)
   - ☐ Dispense Brand Name Reclast®, **NO Generic Substitution**

2. SPECIFY DIAGNOSIS:
   - [ ] Senile osteoporosis (men and postmenopausal women) M81.0
   - [ ] Pathological Fracture neck of femur M81.0 + M84-459A
   - [ ] Pathological fracture other specified part of femur M81.0 + M84.453A
   - [ ] Fracture due to injury: neck of femur M81.0 + S72.019A+S72.099A
   - [ ] Glucocorticoid-induced osteoporosis M81.8
   - [ ] Prevention of glucocorticoid-induced osteoporosis Primary diagnosis code _____ + Z79.52
   - [ ] Paget's disease of the bone M88.9
   - [ ] Osteopenia (infusions are every other year for this diagnosis.) M89.9
     - if patient has Osteopenia + Fracture, use M81.0

3.		PATIENT eGFR 35 ML/MIN OR ABOVE - ATTACH LAB RESULT OBTAINED **WITHIN THE LAST 30 DAYS**
4.		Serum calcium level or ionized calcium level within normal limits - ATTACH LAB RESULT OBTAINED **WITHIN THE LAST 30 DAYS**
5.		Patient has no contraindications to zoledronic acid (pregnancy, hypocalcernia, or hypersensitivity to any component of zoledronic acid). Patient is not receiving Zometa® (zoledronic acid) for any indication. If applicable patient understands that pregnancy should be avoided while on Reclast® therapy.
6.		Patient has been instructed regarding calcium and vitamin D supplementation
7.		Patient has received Randolph Hospital Reclast® Information Sheet
8.		Patient has been instructed to drink at least 2 glasses of fluids within a few hours prior to infusion

☒ZOLEDRONIC ACID (RECLAST®) 5 MG IN 100 ML TO BE INFUSED OVER 30 MINUTES IN THE SPECIAL PROCEDURES UNIT OF THE OUTPATIENT CENTER

☒ Provide patient information sheet to patient.

Practitioner Office Phone:	Practitioner Office Fax:	Office Contact:	
Practitioner Printed Name:	Practitioner Signature: **Product Selection Permitted unless otherwise indicated above**	Date:	Time:

RANDOLPH HEALTH USE ONLY

Infusion scheduled for:	Date:	Time:

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RECLASTORDER

Randolph Health

Revised 1/16/17

Reclast Order Form