

# Randolph Health Order Form: Zoledronic Acid (Reclast®)

<b>PATIENT AND INSURANCE INFORMATION</b>			
<b>Patient Name:</b>			
<b>Date of Birth:</b>		<b>Patient Phone Number:</b>	
<b>Primary ins:</b>		<b>Policy #:</b>	<b>Ph #:</b>
<b>Secondary ins:</b>		<b>Policy #:</b>	<b>Ph #:</b>
<ul style="list-style-type: none"> <li>• <b>Fax the following information to SPU @ 336-629-8844</b></li> </ul>			
1. Most recent office note	* 5. Summary of benefits ( <b>ONLY if Brand name needed</b> )		
2. Medication List	*6. Pre-authorization (if required) ( <b>ONLY if Brand name needed</b> )		
3. Completed Reclast Order Form (this form)			
4. Copies of required labs (see below for requirement)			

<b>CLINICAL INFORMATION AND PATIENT EDUCATION:</b>			
<b>** ALL REQUIREMENTS BELOW MUST BE COMPLETED AND THE CORRESPONDING BOX <u>MUST</u> BE CHECKED BEFORE ZOLEDRONIC ACID INJECTION CAN BE SCHEDULED. **</b>			
2.	Date of last Zoledronic Acid infusion _____ (must be at least 366 days prior to this infusion)		
	<input type="checkbox"/> NO prior Zoledronic Acid (Reclast®) infusions (first treatment) <input type="checkbox"/> Dispense Brand Name Reclast® <b>NO Generic Substitution</b>		
3.	SPECIFY DIAGNOSIS:		
	<input type="checkbox"/> Senile osteoporosis, postmenopausal osteoporosis (ICD-10 #M81.0) <input type="checkbox"/> Osteoporosis, other (ICD-10 #M81.8) <input type="checkbox"/> Osteoporosis, unspecified (ICD-10 #M81.0) <input type="checkbox"/> Osteopenia (infusions every other year for this diagnosis) (ICD-10 #M89.9) <ul style="list-style-type: none"> <li>• If patient has osteopenia + fracture, use ICD-10 #M81.0</li> </ul>		
	INCLUDE ANY ADDITIONAL OR SECONDARY DIAGNOSES AND ICD-10 CODES BELOW:		
4.	Patient eGFR 35 mL/min or above – ATTACH LAB RESULT OBTAINED <b>WITHIN THE LAST 45 DAYS</b>		
5.	Serum calcium level or ionized calcium level within or above normal limits – ATTACH LAB RESULT OBTAINED <b>WITHIN THE LAST 45 DAYS</b>		
6.	Patient has no contraindications to zoledronic acid (pregnancy, hypocalcemia, 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 zoledronic acid therapy.		
7.	Patient has been instructed regarding calcium and vitamin D supplementation		
8.	Patient has received Randolph Health Reclast® information sheet		
9.	Patient has been instructed to drink at least 2 glasses of fluids within a few hours prior to infusion		
	<input checked="" type="checkbox"/> <b>ZOLEDRONIC ACID (RECLAST®) 5 MG IN 100 ML TO BE INFUSED OVER 30 MINUTES IN THE SPECIAL PROCEDURES UNIT OF THE OUTPATIENT CENTER</b> <input checked="" type="checkbox"/> Provide patient information sheet to patient.		
	Practitioner Office Phone:	Practitioner Office Fax:	Office Contact:
9.	Practitioner Printed Name: _____ <i>Product Selection Permitted unless otherwise indicated above</i>		
10.	Practitioner Signature: _____	11. Date: _____	12. Time: _____
<b>RANDOLPH HEALTH USE ONLY :</b>			
Infusion scheduled for:	DATE:		TIME:

