

Randolph Health Order Form: Zoledronic Acid (Reclast®)

1.	PATIENT AND INSURANCE INFORMATION		
Patient Name:			
Date of Birth:		Patient Phone Number:	
Primary ins:		Policy #:	Ph #:
Secondary ins:		Policy #:	Ph #:
Fax the following information to SPU @ 336-629-8844			
1.	Most recent office note	* 5.	Summary of benefits (ONLY if Brand name needed)
2.	Medication List	*6.	Pre-authorization (if required) (ONLY if Brand name needed)
3.	Completed Reclast Order Form (this form)		
4.	Copies of required labs (see below for requirement)		

CLINICAL INFORMATION AND PATIENT EDUCATION:			
** ALL REQUIREMENTS BELOW MUST BE COMPLETED AND THE CORRESPONDING BOX MUST BE CHECKED BEFORE ZOLEDRONIC ACID INJECTION CAN BE SCHEDULED. **			
2.	Date of last Zoledronic Acid 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		
3.	SPECIFY DIAGNOSIS: ☐ Senile osteoporosis, postmenopausal osteoporosis (ICD-10 #M81.0) ☐ Osteoporosis, other (ICD-10 #M81.8) ☐ Osteoporosis, unspecified (ICD-10 #M81.0) ☐ Osteopenia (infusions every other year for this diagnosis) (ICD-10 #M89.9) • If patient has osteopenia + fracture, use ICD-10 #M81.0 INCLUDE ANY ADDITIONAL OR SECONDARY DIAGNOSES AND ICD-10 CODES BELOW:		
4.	Patient eGFR 35 mL/min or above – ATTACH LAB RESULT OBTAINED WITHIN THE LAST 45 DAYS		
5.	Serum calcium level or ionized calcium level within or above normal limits – ATTACH LAB RESULT OBTAINED WITHIN THE LAST 45 DAYS		
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		
☒ 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:
9.	Practitioner Printed Name: _____ <i>Product Selection Permitted unless otherwise indicated above</i>		
10.	Practitioner Signature:	11.	Date:
		12.	Time:
RANDOLPH HEALTH USE ONLY :			
Infusion scheduled for:		DATE:	TIME:



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RECLASTORDER

Reviewed 7/2026
Reclast Orders