

Reclast Order Form

(Zoledronic Acid 5 mg)

FAX TO: 330-294-2082



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg
Primary Language: _____ Allergies: _____
Patient Preferred Location: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

- ☐ M81.0 Age-related Osteoporosis Without Current Fractures
☐ M81.8 Other Osteoporosis Without Current Fracture
☐ M94.9 Disorder of Cartilage, Unspecified
☐ M88. _____ Paget's Disease
☐ M89.9 Disorder of Bone, Unspecified

Other: _____

Secondary Code (IF APPLICABLE)

- ☐ Z79.899 Long Term (Current) Use of
Aromatase Inhibitors

Prescribing Information

A patient being treated with Reclast should not also be treated with Zometa. Reclast is contraindicated in patients with CrCl < 35 mL/min.

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

LAB RESULTS: Include bone density scan results and BMP/CMP within 3 months.

PRESCRIPTION

Reclast (Zoledronic Acid 5 mg)

Dose:

IV: Infuse 5 mg in 100 mL of 0.9% Sodium Chloride over at least 30 minutes once per year

Patient Weight: _____ lbs or _____ kg

Post Treatment Observations: The patient is observed for 30 minutes following the infusion.

Comments: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____
Date: _____ NPI #: _____ Specialty: _____
Supervising Physician: _____ (If Applicable)
Address: _____ City: _____ State: _____ Zip: _____
Contact Name: _____ Phone: _____ Fax: _____ Email: _____