# Reclast® (zoledronic acid)

Referring Physician Order Form Rev. 4/2025

Please fax completed referral form & all required documents to 208-595-4427

## PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

**Patient Status:** ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

**INSURANCE INFORMATION:** ***Please attach copy of insurance card (front and back).***

## DIAGNOSIS*

***ICD 10 Code Required***

☐ Osteoporosis with current fracture (M80.0 – M80.8), ICD10 _____ ☐ Other: _____, ICD10 _____

☐ Osteoporosis without current fracture (M81.0)

## INFUSION ORDERS

| MEDICATION | DOSE | DIRECTIONS/DURATION |
|---|---|---|
| Reclast® (zoledronic acid) | 5 mg | IV over 15 minutes once per year |

**Is patient currently receiving therapy above from another facility?**

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

## PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: _____

## LAB ORDERS

**Labs to be drawn by:** ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ Blood glucose q _____ ☐ CBC with diff/platelet q _____

☐ CMP q _____ ☐ Other: _____

## REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

## REQUIRED CLINICAL DOCUMENTATION

**Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.**

☐ Yes ☐ No Is the patient at high risk for fractures?

*If yes, please select all that apply:*

☐ History of fragility (non-traumatic) fracture

☐ Multiple risk factors for fracture:

- ☐ anorexia nervosa
- ☐ alcohol intake (4 or more units/day)
- ☐ corticosteroid therapy
- ☐ smoking
- ☐ Other: _____
- ☐ elderly
- ☐ low body mass
- ☐ parental history of hip fracture
- ☐ rheumatoid arthritis

### LAB AND TEST RESULTS (required)

☐ Bone Mineral Density (BMD) test ☐ Other: _____

### PRIOR FAILED THERAPIES FOR OSTEOPOROSIS (including oral/IV bisphosphonates, SERM)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

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