Zoledronic Acid Order
(Reclast)

INFUSION FOR HEALTH
InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order. Demographics, Insurance Information, CMP, H&P, Current Medications, Dexa Scan

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: ☐ M81.0 ☐ M81.8 ☐ M81.4 ☐ M89.9

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

DIAGNOSIS

Diagnosis made by: T-Score (Dexas) Please list WORST T-score: Date:

History of Fractures: Please list:

Tried and failed bisphosphonates? Please list:

Center will use Hypersensitivity protocol established by Infusion for Health and P.I

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

ZOLEDRONIC ACID IV DOSAGE:

Date of Last Treatment, If Continuation: _____

5mg IV yearly x 1

Lab work required yearly.

Lab Orders: ☐ List: _____

☐ Prior to first appointment ☐ Other Frequency: _____

☐ Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.