

Palmetto Infusion Services

Phone Number: 800-809-1265 Fax to: 1-(866) 872-8920

MRN _____

STANDARD RECLAST® PLAN OF TREATMENT

Certification dates: From: _____ to: _____

Patient Name: _____ **HT** _____ **WT** _____ **Allergies:** _____

DIAGNOSIS: 733.01 Senile Osteoporosis 731.0 Paget's disease 733.90 Prevention of Osteoporosis in post menopausal women.

Glucocorticoid-Induced Osteoporosis: Pt has been on or will be on Steroids for \geq 12 months

Treatment: Primary diagnosis: 733.09 Glucocorticoid-Induced Osteoporosis
Secondary diagnosis E932.0 Adrenal Cortical Steroid (dosage equivalent to 7.5 mg of prednisone daily)

Prevention: Primary Diagnosis: _____ ICD-9 Code: _____
Secondary Diagnosis V58.65 Long term (current) use of Steroids

Is the patient on calcium and Vitamin D replacement? Yes No

Patient must have a calculated serum creatinine clearance of greater than/equal to 35ml/min and a normal serum calcium level.
(Must have copy of lab results within 60 days)

Orders: Reclast 5mg/100ml administration over at least 15 minutes X 1 Dose

Obtain weight each visit. Obtain vital signs per and post IV administration, then after 15 minute post infusion wait. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient for response to therapy.

If adverse drug reaction, implement the Standing Adverse Reaction Protocol.

Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn.

Normal Saline Flush 3-10 ml before infusion, after primary drug has infused, Infuse Normal Saline 0.9% or D5W 20-50 ml to flush tubing/line followed by Heparin Lock 1 – 5 ml 100 unit/ml as needed per line type.

Pump, tubings, and supplies needed to complete prescribed therapy. Pharmacist to perform clinical drug monitoring.

South Carolina Medicare Reclast Addendum (Medicare Patients only)

This is a guideline for therapy based on the LCD. Other diagnoses may be used if they fall within the South Carolina Medicare guidelines for this therapy.

Is the patient . . .

- A postmenopausal woman or
- A man 50 years old or more?

Does the patient have documentation of one of the following?

- History of a vertebral or hip fracture
- A T-score less than -2.5 in the femoral neck, total hip or spine
- Other prior fracture (**specify site:** _____) **and** low bone mass (T-score -1.0 to -2.5 at the femoral neck, total hip or spine)
- Low bone mass (as described above) **and** other conditions such as: **Specify:** _____
 glucocorticoid use immobilization other _____
- Low bone mass (as described above) with a 10-yr probability of hip fracture > 3% based on the US adapted WHO algorithm
- Low bone mass (as described above) with a 10-yr probability of any major osteoporosis related fracture >20% based on the US adapted WHO algorithm

and one of the following:

- Documented allergy to shellfish and/or salmon
- Documented intolerance to oral bisphosphonate therapy due to medical or surgical conditions such as:**
- Severe esophageal disease (ulcerations, strictures). **Specify:** _____
- Esophageal problems or difficulty swallowing severe enough to cause a patient to be non-compliant with oral bisphosphonates. **Specify:** _____
- Inability to take anything by mouth. **Due To:** _____
- Inability to sit or stand for at least 30 minutes
- Intestinal malabsorption. **Specify:** _____
- Documented non-compliance with oral bisphosphonates for at least 3 months.
- Other (**Specify diagnosis & code:** _____)

No Stamped Signatures Please

Physician's Signature: _____ / _____ **Date:** _____
(Dispense as written) (Substitution Permitted)

Print Physician's Name: _____