Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Zoledronic Acid (generic for Reclast®) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies:	☐ See list ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	M81.0 - Age-related Osteoporosis without current fractures	☐	M89.9 - Disorder of bone, unspecified
☐	M81.8 - Other osteoporosis without current fracture	☐	M94.9 - Disorder of cartilage, unspecified
☐	M88. - Paget's disease	☐	Z92.241 - History of systemic steroid therapy **(SECONDARY)**
☐	Z79.52 - Long term use of systemic steroids **(SECONDARY)**	☐	_____ - Other:_____

REQUESTED DOCUMENTATION:			PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	BMP results within last 30-60 days is preferred		☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive Zoledronic Acid if creatinine clearance is <35 ml/min or serum calcium is below normal range

MEDICATION/DOSE:

☑ **Zoledronic Acid 5mg/100ml IV administration single dose (x1) over 30 minutes**

LAB PARAMETERS: (Pharmacist to perform clinical lab monitoring)

Creatinine clearance </=35 ml/min: dose will be held unless written clearance is provided by MD

Serum Calcium is below normal range: dose will be held unless written clearance is provided by MD

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	

ACCURX
INFUSION CENTER
A PALMETTO INFUSION COMPANY

Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com

02/08/2023