

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/> 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	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	BMP results within last 30-60 days is preferred	THERAPY:	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 $\leq 35\text{ ml/min}$: 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: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.	
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PRESCRIBER INFORMATION:

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

PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

<input type="text"/>		<input type="text"/>
Dispense as written/Brand medically necessary		Substitution permitted