

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 2 ND AND 3 RD 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 </=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:	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. 

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



Palmetto

INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com