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

Rev 4.29.25

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

PATIENT DEMOGRAPHICS:

Patient Name:	
Patient's Phone:	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:____________________________________

REQUIRED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	BMP results within last 30-60 days is preferred

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
	NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **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. ONJ is a risk for patients receiving zoledronic acid. A routine oral exam is recommended to be performed by the prescriber prior to initiation of zoledronic acid treatment.

MEDICATION/DOSE:

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

☐ Prescriber clearance waived for recent or planned dental procedures.

LAB PARAMETERS:

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

☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

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

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	

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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.palmettoinfusion.com