US infusions

RECLAST/ZOLEDRONIC ACID INJECTION ORDERS:

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION:

☐ M80.0 – Age-related osteoporosis with current fracture

☐ M81.8 – Osteoporosis w/o current fracture

☐ M80.8 – Other osteoporosis with current fracture

☐ M81.0 – Age-related osteoporosis w/o current pathological fracture

☐ Other diagnoses:_____

THERAPIES TRIED AND FAILED:

Bisphosphonates for osteoporosis with start and end dates and reasons for discontinuation (intolerance, contraindications, fractures, impaired kidney function):

_____

REQUIRED ASSOCIATED DOCUMENTATION:

☐ Patient demographics ☐ Front/back of all insurance cards ☐ Current medication list

☐ Include clinical notes supporting one or more of the above diagnoses.

☐ Include Dexa scan results to support osteoporosis diagnosis: ☐ T-score of < -3.0 overall, ☐ T-score of ≤ - 2.5 in the lumbar spine, femoral neck, total proximal femur, or 1/3 radius, ☐ T-score between -1.0 and -2.5 *and* a fragility fracture of the proximal humerus, pelvis, or distal forearm.

☐ Include lab test results: ☐ CMP reflecting normal calcium levels and kidney function.

☐ Include all supporting diagnostic radiographic reports and images of fractures attributed to one or more of the above diagnoses.

Therapy orders: ☐ ZOLEDRONIC ACID 5MG IV INFUSION OVER 15 MINUTES

Premedication: Tylenol 1000mg ___or Ibuprofen 400mg ___

REFERRING PROIDER INFORMATION:

Provider name: _____ Signature:_____ Date:_____

NPI: _____ Phone: _____ Fax: _____

FAX COMPLETED FORM TO US INFUSIONS AT 469-200-2606

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