



# Zoledronic Acid/Reclast

New Referral  Continuing Treatment  Medication Order Change

### Patient Information:

Name: \_\_\_\_\_  
Date: \_\_\_\_\_  
DOB: \_\_\_\_\_  
SS#: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Email: \_\_\_\_\_

### Physician Information:

Referring Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_

### Medication Orders

Patient Weight: \_\_\_\_\_ kg Patient Height: \_\_\_\_\_ inches Has the patient had any fractures?  Yes  No

First Dose  Continuing care: current infusion # \_\_\_\_\_

Patient currently taking Calcium/Vitamin D supplement?  Yes  No

Dosing:  **5 mg IV every year (new order needed every infusion, every year)**

Indication / Diagnosis:

- M81.0 Age related osteoporosis w/o current pathological fracture
- M81.8 Other osteoporosis w/o current pathological fracture
- Other (please specify) \_\_\_\_\_

**ICD-10 (Required)** \_\_\_\_\_

**MD Signature:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Required Documentation

Please send the following documents and records. This will help streamline the pre-authorization process.

- **If this is a continuation of a treatment, include the last infusion note**
- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- Current medication list

Most recent diagnostics results to include:

- CMP/BMP
- Vit D
- DEXA (within 2 years)
- Ionized Calcium (if applicable)
- Creatinine

*We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.*

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