

RECLAST (zoledronic acid) Infusion Orders

Patient Name: _____ DOB: _____ ☐ M ☐ F

☐ NKDA Allergies: _____

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____ Provider NPI: _____

Practice Phone: _____ Practice Fax: _____

Diagnosis *(please provide ICD-10 code):*

☐ _____
ICD-10 Diagnosis

Pre-Medication:

- ☐ Tylenol 1000mg PO ☐ Solu-Medrol 125mg IVP
☐ Cetirizine 10mg PO ☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg PO ☐ Diphenhydramine 25mg IVP
☐ Other: _____

Required Documents:

- ☒ Patient Demographic Sheet
☒ Clinical/Progress Notes supporting primary diagnosis *(please attach)*
☒ DEXA Scan results & date *(please attach)*
☒ Calcium level & date *(please attach)*

RECLAST ORDERS:

Dosing: ☒ 5mg/100ml IV infusion over at least 15 minutes

Frequency: ☒ Once annually ☐ Other: _____

☒ No Refills

Red River Health Standing Orders:

- ☒ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: _____ Date: _____