LIFE SPECIALTY SOLUTIONS

RECLAST

PATIENT INFORMATION

PATIENT NAME: PHONE #:

ADDRESS: CITY, STATE, ZIP:

DATE OF BIRTH: EMAIL:

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List
6. DEXA Scan 7. Current Calcium Level (within 6 months) 7. CrCl clearance

PRIMARY DIAGNOSIS

☐ M80.00xA Age-related osteoporosis with current pathological fracture, initial encounter
☐ M80.00xS Age-related osteoporosis with current pathological fracture, sequela
☐ M81.0 Age-related osteoporosis without current pathological fracture
☐ Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: There are no recommended standard pre-meds
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Reclast IV

☐ Reclast (Zoledronic Acid) 5mg IV x 1 dose ☐ Other _____

FIRST DOSE?: ☐ Yes ☐ No

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: PHONE:

OFFICE CONTACT: FAX:

ADDRESS: EMAIL:

CITY, STATE, ZIP: NPI AND LICENSE:

✖ _____ _____

PROVIDER SIGNATURE DATE