Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Reclast (Zoledronic Acid)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:
Patient Weight: _______ kg or _______ lb	Patient Height: ______ in

REFERRAL STATUS
☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)
☐ Richmond ☐ Prince George

* * If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access * *

DIAGNOSIS AND ICD-10 CODE	
☐ Osteoporosis w/o current pathological fracture	M81.0
☐ Osteoporosis with current pathological fracture*	M80.0________
*If with fracture, please provide the specific diagnosis code that is 7 digits w/ letters	
☐ Other Diagnosis:	ICD10 ____

REQUIRED DOCUMENTATION (must include)	
☐ This signed order form by the provider	☐ Clinical/Progress Notes
☐ Patient Demographics AND Insurance Information	☐ Labs and Tests Supporting Primary Dx
☐ DEXA scan results and/or FRAX score	
List Tried & Failed Therapies, including duration of treatment (please comment specifically on bisphosphonates):	
1)	
2)	
3)	

MEDICATION ORDERS	
Dosing:	☐ Reclast 5mg infuse IV over 30 minutes once yearly
	☐ Reclast 5mg infuse IV over 30 minutes once every 2 years
Duration: ☐ x 6 months ☐ x 1 year ☐ doses _______________	

OPTIONAL PREMEDICATIONS and LAB ORDERS
☐ Acetaminophen 650mg PO prior to infusion
☐ Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion
☐ Methylprednisolone 40mg slow IVP prior to infusion
☐ CBC and CMP at each administration
☐ Other PreMed or Lab Order with frequency: ____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
Fax completed form and ALL required documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.