Agile Infusion Services LLC

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RECLAST MEDICATION ORDER

Patient's Name (Last, First, Middle) ____________________________ DOB _______________________

Patient's height in feet and inches _____________________ *Patient's weight in pounds*__________________________

■ Diagnosis

☐ M80.0______ Age-related osteoporosis w/fx at _______ ☐ M81.8 Other osteoporosis w/o fx

☐ M81.0 Age-related osteoporosis w/o fx ☐ _______________________________

Note: *M80.0____ requires the* <u>*complete*</u> *ICD-10 code, with 3 digits and a letter after the decimal. Some insurance carriers may not accept all such codes.*

■ Details Needed for Approval

Please answer all questions and provide supporting documentation.

- If female, does the patient have a BMD T-score ≤-2.5? _____ Osteopenia with T-score between -1 and -2.5? _____
- Has the patient had a low-trauma spine or hip fracture? _____
- Has patient failed a trial on, or is intolerant to, bisphosphonate and/or other osteoporosis therapy? _____
- Is the patient considered at high risk of fracture? _____ Please provide all supporting documentation.
- Please provide the patient's most recent calcium levels. (Most insurers want results from the past 4 weeks.)
- Is patient planning to concomitantly take parathyroid hormone analogs, RANK ligand inhibitors, or bisphosphonates? _____
- Will the patient be taking a daily supplement of at least 1000mg calcium and at least 400 IU vitamin D? _____

■ Premedication Order

Oral medications to be taken by the patient at least 60 minutes prior to start of infusion treatment. May be taken at home:

☐ Acetaminophen _____mg ☐ Diphenhydramine _____mg ☐ Cetirizine 10mg

IV medications to be administered prior to start of the infusion treatment (for infusions only, not for injections):

☐ Diphenhydramine _____mg ☐ Methylprednisolone _____mg ☐ _______________________

■ Medication Order

☐ Reclast (zoledronic acid) 5mg in 100ml normal saline IV infusion over 30 minutes. One treatment, no refills.

■ Rescue Management in Case of Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ Ordering Provider Authorization

Provider Signature: ___________________________ Name: __________________ Date: ____________________

Address: ____

Phone: _______________ Fax: ________________ Indiv. NPI #: ____________ License: _______________

Best Contact Person in Office: ________________________ Direct Phone to Contact Person: ____________________

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.