

RECLAST

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER

Prescriber Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

CLINICAL

Diagnosis: ☐ M80. _____ ☐ M81. _____ ☐ M88. _____ ☐ Z79. _____ ☐ Other: _____

Allergies: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in

SCr Completed: ☐ Yes ☐ No CrCl/eGFR Reviewed: ☐ Yes ☐ No

TREATMENT

RECLAST (zoledronic acid)

Route: Intravenous infusion

Dose: ☐ 5mg

Frequency:

☐ Once yearly

☐ Other: _____

Quantity: _____

Premedication Protocol: *(Not Usually Indicated)*

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

☒ Center will use anaphylactic and hypersensitivity protocol established by Cure Stat Infusion Services.

Special Instructions: _____

Provider Signature: _____

Date: _____