McLeod Health

Place Sticker Here

Zoledronic Acid (Reclast) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one):

☐ M81.0 Age-related Osteoporosis without current fractures

☐ M81.8 Other osteoporosis without current fractures

☐ Other: ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders:

• Zoledronic Acid (Reclast) (J3489) 5 mg/100 mL IV Piggyback over 30 minutes for one dose

● Other: _____

Standing Orders:

• Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Pre-Screening Requirements:

☐ BMP prior to each dose

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received zoledronic acid at another facility, please provide last date received: _____
- If patient has previously received another bisphosphonate therapy, please provide the name: _____

and the last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Cheraw: 843-320-3469 (Fax)

843-320-5557 (Phone)