

# McLeod Health

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## 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.

Dillon: 843-487-1491 (Fax)

843-487-1334 (Phone)