

Reclast Order Form

Pre-filled order form for Reclast (zoledronic acid) — Once-yearly osteoporosis infusion

REFERRING PROVIDER

PROVIDER NAME	NPI	DEA (IF CONTROLLED)	SPECIALTY
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PRACTICE / CLINIC NAME	OFFICE PHONE	OFFICE FAX
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OFFICE CONTACT NAME	CONTACT PHONE	CONTACT EMAIL
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PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL
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DATE OF BIRTH	SEX	PATIENT PHONE	BEST TIME TO CONTACT
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ADDRESS	CITY, STATE, ZIP
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INSURANCE

PRIMARY INSURANCE	MEMBER ID	GROUP #
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SECONDARY INSURANCE (IF ANY)	MEMBER ID	GROUP #
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DIAGNOSIS & CLINICAL JUSTIFICATION

PRIMARY DIAGNOSIS	ICD-10 CODE
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SECONDARY DIAGNOSIS (IF APPLICABLE)	ICD-10 CODE
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Common indications for this medication: *Postmenopausal osteoporosis, Osteoporosis in men, Steroid-induced osteoporosis, Paget's disease of bone*

BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY

PRIOR THERAPIES TRIED AND OUTCOME
RECLAST REFERENCE

Generic name: zoledronic acid
Specialty: Bone Health
Typical infusion time: About 15 minutes
Typical schedule: Once a year
Biosimilars / brands: Aclasta

MEDICATION ORDER

MEDICATION (DEFAULT: RECLAST)		GENERIC / ALT (ZOLEDRONIC ACID)	STRENGTH / FORMULATION
DOSE	FREQUENCY (TYPICAL: ONCE A YEAR)	DURATION (TYPICAL: ABOUT 15 MINUTES)	
ROUTE	PRE-MEDICATIONS (IF ANY)	SPECIAL INSTRUCTIONS	
ANTICIPATED START DATE	# OF DOSES AUTHORIZED	SUBSTITUTION ALLOWED (Y/N)	BIOSIMILAR ACCEPTABLE (Y/N)

REQUIRED LABS & MONITORING

Check all labs the prescriber requires Arbor to verify before each infusion:

- | | | |
|--|--|---|
| <input type="checkbox"/> CBC w/ differential | <input type="checkbox"/> CMP | <input type="checkbox"/> Liver function panel |
| <input type="checkbox"/> Hepatitis B/C panel | <input type="checkbox"/> TB screen (T-SPOT or QFT) | <input type="checkbox"/> Pregnancy test (urine) |
| <input type="checkbox"/> Iron studies (ferritin, TSAT) | <input type="checkbox"/> Vitamin levels (B12, D, folate) | <input type="checkbox"/> Other (specify below) |

OTHER LABS / MONITORING REQUIREMENTS
PRESCRIBER SIGNATURE

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Arbor Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

PRESCRIBER SIGNATURE
PRINTED NAME
DATE

Form code: ARB-ORDER-RECLAST · Submit to Arbor Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Arbor will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@arborinfuse.com