Provider Order Form

RECLAST (ZOLEDRONIC ACID)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Osteoporosis M80. _____ ☐ Osteoporosis M81. _____

☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ RECLAST (Zoledronic Acid), IV	☒ 5 mg	☐ Once yearly
		☐ Other _____

Other: _____

☒ Infuse over at least 15 minutes

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance Card ☐ Progress Notes Supporting DX ☐ Bone density results

☐ Serum creatinine within 1 month of referral

Provider Signature _____ Date _____