MATAGORDA REGIONAL
MEDICAL CENTER
MRMC IV THERAPY SERVICES
PHONE: 979-241-5966
FAX: 979-241-5965

RECLAST 5 mg / 100 ml IVPB ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ WT: _____ Sex :( ) Male ( ) Female SSN:_____ Home #:_____ Cell#:_____

Street Address_____ City/State/Zip _____

Allergies:_____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

PHYSICIAN / FACILITY INFORMATION

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

DEA#:_____ NPI #:_____ State Lic #:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 CODE)

_____Date of Diagnosis: _____

Does patient have venous access? ☐ **YES** ☐ **NO**

If yes, what type: ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

a) ALLMEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
b) ADMINISTER CATH-FLO 2MG, IVP PER PORT IF PICC LINE BECOMES SLUGGISH OR OCCLUDED; MAY REPEAT AFTER 2 HRS IF NEEDED X 1

PRESCRIPTION ORDERS

NOTE: RECLAST (ZOLEDRONIC ACID) IS CONTRAINDICATED IN PATIENTS WITH CrCl < 35 ml/min AND/OR IF HYPOCALCEMIA

ADMINISTER RECLAST (ZOLEDRONIC ACID) 5 mg/100ml, IVPB
OVER NO LESS THAN 15 MINUTES ONE TIME A YEAR

INCLUDE COPIES OF THE FOLLOWING:

- **BUN, CREATININE, and CALCIUM MUST BE CHECKED WITHIN THE LAST 30 DAYS OTHERWISE HOSPITAL WILL COLLECT LABS PRIOR TO INFUSION.**
- **BONE DENSITY/DEXA SCAN WITHIN THE LAST 2 YEARS – OTHERWISE ONE WILL BE PERFORMED PRIOR TO THE DATE OF SERVICE BY THE ORDERING PHYSICIAN BEFORE SCHEDULING APPOINTMENT**
- **OFFICE NOTES SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS/OSTEOPENIA DATED WITHIN THE LAST 2 YEARS**
- **H+P DATED WITHIN THE LAST 2 YEARS**
- **PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS/OSTEOPENIA MUST BE DOCUMENTED IN PATIENT'S MEDICAL RECORD. Examples: Oral calcium, Vitamin D**

Labs Needed: **BUN, CREATININE, AND SERUM CALCIUM (if previous results not provided within last 30 days)**

Signature:_____**Time:**_____ **Date:**_____

Revised 07/2022

Fax completed form to the MRMC Infusion Center at 979-241-5965.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.