



MATAGORDA REGIONAL
 MEDICAL CENTER
 MRMCM 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) ALLMEDIPOINTS/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 IONIZED 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 IONIZED CALCIUM (if previous results not provided within last 30 days)**

Signature: _____ Time: _____ Date: _____

Reviewed 04/2026

Fax completed form to the MRMCM 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.