



ZOLEDRONIC ACID ORDER FORM

(* - Required Fields)

 STAT REQUEST
(*REASON MUST BE PROVIDED BELOW)

<u> </u> New Referral	<u> </u> Order Renewal	<u> </u> Medication/Order Change
<u> </u> Benefits Verification Only	<u> </u> Discontinuation Order	

Locations:

-----Oklahoma-----
 Tulsa

PATIENT INFORMATION			
NAME*:	DOB*:	SEX:	M F
ADDRESS:		PHONE:	
WEIGHT:	LBS KG	HEIGHT:	EMAIL:
ALLERGIES:			

PHYSICIAN INFORMATION			
PHYSICIAN NAME*:		PRACTICE NAME:	
ADDRESS:		OFFICE CONTACT*:	
PHONE:	FAX:	EMAIL (FOR UPDATES):	

<p><u>ZOLEDRONIC ACID ORDER*</u>: <i>(SELECT ONE OF THE FOLLOWING)</i></p> <p><u> </u> Dosing: 5mg IV every <u> </u> year(s)</p> <p>Patient is currently taking Calcium/Vitamin D Supplement: <u> </u> Yes <u> </u> No</p> <p>Physician Signature* _____</p>	<p>ICD-10*: _____</p> <p>Date*(Order is Valid for One Year) _____ <i>Infusion will be administered per policy and protocols</i></p>
---	---

REQUIRED DIAGNOSIS:
<p><u> </u> Osteoporosis</p> <p><u> </u> Osteoporosis Postmenopausal</p> <p><u> </u> Glucocorticoid-induced Osteoporosis</p> <p><u> </u> Paget's Disease</p> <p><u> </u> Osteopenia/Prevention of Osteoporosis</p> <p><u> </u> Other _____</p> <p>*STAT REASON: (STAT request will be assessed per MPP policy and protocol)</p>

REQUIRED DOCUMENTATION CHECKLIST:
<p><u> </u> Patient Demographics</p> <p><u> </u> Insurance Card/Information</p> <p><u> </u> Clinical/Progress Notes supporting DX</p> <p><u> </u> Current Medication List and H&P</p> <p><u> </u> Serum Calcium (w/in 90 days)</p> <p><u> </u> DEXA Results</p> <p><u> </u> Creatinine (w/in 90 days)</p> <p>Last Infusion/Injection Date: _____</p>

<p>STANDING LAB ORDERS: <u> </u> CMP <u> </u> CBC</p> <p><u> </u> Labs to be drawn by Infusion Center Frequency _____</p>

<p>NOTES/ADDITIONAL COMMENTS:</p>
--