Reclast Order Form

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

REFERRING PROVIDER

PROVIDER NAME | NPI | DEA (IF CONTROLLED) | SPECIALTY

PRACTICE / CLINIC NAME | OFFICE PHONE | OFFICE FAX

OFFICE CONTACT NAME | CONTACT PHONE | CONTACT EMAIL

PATIENT INFORMATION

PATIENT LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH | SEX | PATIENT PHONE | BEST TIME TO CONTACT

ADDRESS | CITY, STATE, ZIP

INSURANCE

PRIMARY INSURANCE | MEMBER ID | GROUP #

SECONDARY INSURANCE (IF ANY) | MEMBER ID | GROUP #

DIAGNOSIS & CLINICAL JUSTIFICATION

PRIMARY DIAGNOSIS | ICD-10 CODE

SECONDARY DIAGNOSIS (IF APPLICABLE) | ICD-10 CODE

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 Ascribe to verify before each infusion:

- ☐ CBC w/ differential
- ☐ CMP
- ☐ Liver function panel
- ☐ Hepatitis B/C panel
- ☐ TB screen (T-SPOT or QFT)
- ☐ Pregnancy test (urine)
- ☐ Iron studies (ferritin, TSAT)
- ☐ Vitamin levels (B12, D, folate)
- ☐ 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. Ascribe 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 Ascribe Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Ascribe Infusion will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@ascribeinfusion.com