

Zoledronic Acid



Ph: 518-836-3030 | Fax: 518-836-3020

Date: _____

Please include the following to expedite the order

Demographics, Insurance Information, Last Progress Note Relevant to the Diagnosis, Current Medications, BMP, Vitamin D, Recent DEXA Scan

PATIENT INFORMATION

PRESCRIBER INFORMATION

Patient Name: _____

Prescriber's Name: _____

Patient Contact Number: _____

NPI: _____ Date: _____

DOB: _____

Phone: _____ Fax: _____

Allergies: _____

Office Address: _____

Weight: _____ ○ lbs ○ kg Height: _____

Contact Person: _____

Diagnosis: _____

Contact Email: _____

ICD 10: _____

☐ Please check this box if you **DO NOT** authorize UHO to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

PREMEDS

Pre-Medications not usually indicated

☐ No Premeds

Benadryl: ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

Acetaminophen: ☐ PO ☐ 650 mg ☐ Other: _____

Methylprednisolone: ☐ IV ☐ _____ mg

Other: _____

☐ You authorize UHO to utilize the hypersensitivity protocol established by UHO.

Signature: _____

Date: _____

ZOLEDRONIC ACID DOSAGE

Date of Last Treatment, if Continuation: _____

Route: IV

Dose: 5 mg

Frequency: Every 12 months

(if not indicated order will expire 6 months from date signed)

To ensure that a Brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, UHO is authorized to administer generic or biosimilar.

LAB ORDERS

☐ No Labs

List: _____

Frequency: _____

Signature: _____

Date: _____