Zoledronic Acid (Reclast)

Provider Order Form rev. 06/24/26

Optimum INFUSION

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per Optimum Infusion Nursing Procedures, including reaction management and post-procedure observation.

☑ Serum Creatinine level and date (Please provide results)

_____

☑ Serum Calcium level and date (Please provide results)

_____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

☑ Zoledronic acid (Reclast) 5mg/100ml intravenous infusion over 30 minutes

- Frequency: once yearly
- Rate: Infuse over no less than 30 minutes
- No refills

☑ Flush with 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 30-minute observation

PRODUCT SUBSTITUTION NOTICE

☑ Optimum Infusion will dispense the most appropriate zoledronic acid formulation based on patient's insurance coverage. Prescribing provider will be notified of the selected product.

Prior to administration of each dose of Reclast, obtain a serum creatinine and creatinine clearance should be calculated based on actual body weight using Cockcroft-Gault formula before each Reclast dose. Reclast is contraindicated in patients with creatinine clearance less than 35 mL/min and in those with evidence of acute renal impairment.

Pre-existing hypocalcemia and disturbances of mineral metabolism (e.g., hypoparathyroidism, thyroid surgery, parathyroid surgery; malabsorption syndromes, excision of small intestine) must be effectively treated before initiating therapy with Reclast.

Provider Name (Print) **Provider Signature** **Date**

SUBMIT ORDER FORM TO OPTIMUM INFUSION:
☐ **FAX:** 505-420-4848
☐ **EMAIL:** refer@optimuminfusion.com