



Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

RECLAST ORDER FORM

New Start **Maintenance: Last Dose Given** _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____		
Height: _____ Weight: _____		

Indication:

M81.0 Senile Osteoporosis without current fracture

M85.89 Disorder of bone density

M88 Paget's Disease of bone

M81. ___ Glucocorticoid-induced osteoporosis

Other _____

DOSAGE ORDERS:

5mg IV X 1 dose

Other _____

PREMEDICATION ORDERS:

Acetaminophen: 1000mg PO 500mg PO 30 min prior to infusion. -REQUIRED

Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.

Methylprednisolone: 62.5mg IVP 125mg IVP Other _____ 30 min prior to infusion.

Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
 - CBC CMP TB Hep B Calcium Creatinine Clearance is above 35ml/min.
 - Serum creatinine
 - Vitamin D level
 - Other: _____

DISCLAIMER: Referring provider attests they have instructed patient to take adequate calcium and vitamin D supplementation. Prescriber acknowledges responsibility for ongoing clinical lab monitoring.