

Zoledronic Acid Enrollment Form

TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012



Date: _____
 Patient Name: _____
 Date of Birth: _____

PREVIOUS ADMINISTRATION

If YES, please provide the following information:

Last Infusion Date: _____
 Next Infusion Date: _____

If NO, please indicate desired location for first dose:

Physician's Office
 TwelveStone Infusion Center:
 Canton Chattanooga Knoxville Mount Juliet Murfreesboro
 Other: _____
 Desired Start Date: _____

DIAGNOSIS

Description

Osteoporosis Other: _____

ICD-10 Code

M80.0 M81.0 Other: _____

OTHER REQUIRED DOCUMENTATION (Please attach required documents)

This signed order form History and Physical
 Patient Demographics and Insurance Information Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

Patient Weight: _____ Kg Height: _____ Inches/CM BSA: _____ Allergies: _____
 Line Access: PIV PICC (SL DL TL) PORT (Huber size _____ Gauge _____ Length) Other Access: _____

MEDICATION DIRECTIONS REFILLS Baseline Labwork required to initiate therapy (check for TwelveStone to draw)

<input type="checkbox"/> Zoledronic Acid	<input type="checkbox"/> Infuse 5 mg IV over 15 minutes every ____ years.		<input type="checkbox"/> Baseline Calcium level within last 60 days
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LAB ORDERS (to be drawn by TwelveStone)

<u>Order</u>	<u>Frequency</u>
CBC w/Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
CBC w/o Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
CMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
BMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
CRP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Sed Rate	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Calcium	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Tb QuantiFERON Gold	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Hepatitis Panel	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Other _____	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____

PRE-MEDICATIONS/No Pre-Meds please check here _____

<u>Oral</u>	<u>IV</u>
Acetaminophen: <input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg	Dexamethasone: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg
Cetirizine: <input type="checkbox"/> 10mg	Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg
Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg
Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	Methylprednisolone: <input type="checkbox"/> _____mg IV over _____ mins
Ibuprofen: <input type="checkbox"/> 200mg	Ondansetron: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg
Loratidine: <input type="checkbox"/> 10mg	
Ondansetron: <input type="checkbox"/> 4mg	

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone # _____ Physician's NPI# _____ Physician's Fax # _____ Physician's Address _____
 Dispense as Written _____ Date _____ Substitution Allowed _____ Date _____

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