TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

ZOLEDRONIC ACID ORDER FORM

Date: Patient Name: Date of Birth:	ICD-10 Code: _____ Allergies: _____ Weight: _____lbs OR _____kg

Therapy Status	Provider Information
☐ New Start ☐ Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER

☐ Zoledronic Acid	Administer Zoledronic Acid 5mg IV over at least 15 minutes x one dose.	Prescriber Considerations: *Hypocalcemia may worsen during treatment. Therefore, patients should adequately supplement with calcium and vitamin D. *Due to risk of osteonecrosis of the jaw, prescriber should perform routine oral exam prior to treatment. *Contraindicated in patients with a CrCl less than 35mL/min and in those with evidence of acute renal impairment.	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: ☐ Serum calcium within 60 days prior to each dose. ☐ Serum creatinine within 60 days prior to each dose.

PRE-MEDICATIONS

Oral	IV
☐ Acetaminophen: ___325mg ___500mg __650mg	☐ Dexamethasone: ___4mg ___8mg
☐ Loratadine: 10 mg	☐ Diphenhydramine: ___25mg __50mg
☐ Cetirizine: 10mg	☐ Famotidine: ___20mg ___40mg
☐ Diphenhydramine: ___25mg ___50mg	☐ Methylprednisolone 125mg
☐ Famotidine: ___20mg ___40mg	☐ Hydrocortisone 100mg
☐ Ibuprofen: ___200mg ___400mg ___600mg	☐ Ondansetron: ___4mg ___8mg
☐ Ondansetron: ___4mg ___8mg	☐ Other_____
☐ Other_____	

LAB ORDERS (Please indicate any labs to be drawn and frequency)	OTHER REQUIRED DOCUMENTATION
Surveillance lab ordering, and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work

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

Dispense as Written: _____ _____ Prescriber Name Date	Substitution Allowed: _____ _____ Prescriber Name Date