RECLAST

FAX: 725.228.5220

eMediate INFUSION

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

PATIENT INFORMATION

*Please attach the copy of patient insurance & ID (front and back)

Name:	DOB:	Weight: kg

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	*Email (for the referral update):	
Clinic:	Address:	
NPI:		
Patient's PCP Name:	Phone:	Fax:
Clinic:	Address:	
NPI:		

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Reclast:
(zoledronic acid)

☐ 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

☐ Others: _____

_____

Pre-Medication:

☐ Solumedrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Others: _____

☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg

☐ Benadryl _____ mg PO
☐ 25 mg ☐ IV
☐ 50 mg ☐ PO

ANA Kit Protocol:

☐ OK to use

Dx:

Diagnosis: _____

Other: _____

ICD-10: _____

PRESCRIBER SIGNATURE: x

Date (Valid for 1 year):

I authorize eMediate Infusion Center, PLLC , Assist Point Clinical or its authorized representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to eMediate Infusion Center.

REQUIRED INFORMATION

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.