



OUTPATIENT INFUSION CENTER

Phone: 931-438-1100

Fax: 1-931-438-1219

ZOLEDRONIC ACID 5mg/100mL IVPB Order Forms

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex :( ) Male ( ) Female
SSN: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ Allergies: \_\_\_\_\_
Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_
Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Insurance Information:

Primary Insurance Name \_\_\_\_\_ Policy ID #: \_\_\_\_\_
Secondary Insurance Name \_\_\_\_\_ Policy ID #: \_\_\_\_\_

Physician Information:

Physician's Name: \_\_\_\_\_ Referral Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_
Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_
DEA#: \_\_\_\_\_ NPI #: \_\_\_\_\_ Fax #: \_\_\_\_\_
State License #: \_\_\_\_\_

Statement of Medical Necessity

Primary Diagnosis: (ICD-10 Code plus Description) \_\_\_\_\_
Date of Diagnosis: \_\_\_\_\_

ACCESS: Does the patient have venous access? [ ] Yes [ ] No If Yes, what type? \_\_\_\_\_

Orders:

\*\*\*Normal Saline will be used to clear all lines. All MEDIPORTS/PORTS/VAD will be flushed with Heparin and Saline per hospital protocol. \*\*\*

[ ] Do not administer Heparin to this patient. [ ] Insert PIV [ ] Insert PICC

ADMINISTER ZOLEDRONIC ACID 5MG/100mL, IVPB
OVER NO LESS THAN 15 MINUTES ONE TIME A YEAR

INCLUDE COPIES OF THE FOLLOWING:

- BUN, CREATININE, and CALCIUM MUST BE CHECKED WITHIN THE LAST 30 DAYS OTHERWISE HOSPITAL WILL COLLECT LABS PRIOR TO INFUSION.
BONE DENSITY/DEXA SCAN WITHIN THE LAST 2 YEARS – OTHERWISE ONE WILL BE PERFORMED PRIOR TO THE DATE OF SERVICE
OFFICE NOTES SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS/OSTEOPENIA DATED WITHIN THE LAST 2 YEARS
H+P DATED WITHIN THE LAST 2 YEARS
PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS/OSTEOPENIA MUST BE DOCUMENTED IN PATIENT'S MEDICAL RECORD. Examples: Oral calcium, Vitamin D

Labs Needed: BUN and CREATININE and CALCIUM (if previous results not provided within last 30 days) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_ Time: \_\_\_\_\_

Fax completed form to the Outpatient Infusion Center at 1 (931) 438-1219.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.