Updated December 3, 2018

Checklist for Reclast (zoledronic acid) Referral

Required documentation for all initial referrals

Patient ________________________________DOB______________ Date_________ ☐ New Start ☐ Maintenance

Please return **completed** checklist and checklist items for an infusion referral:

- ☐ Patient demographics (e.g. address, phone number, SSN, etc.)
- ☐ Insurance information and copy of insurance card(s). Please indicate the insurance that is primary, and the insurance that is secondary, if applicable, and the subscriber's date of birth.
  - If insurance requires prior authorization, please provide the phone number and allow up to 15-30 days for this to be completed by one of our Infusion Coordinators.
- ☐ Signed and completed Reclast Standard Order (our order form) with ICD diagnosis code
  - *Standard Order forms are available at lowcountryrheumatology.com/infusions/*
- ☐ Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy, how long patient has taken bisphosphonate therapy and if it has been taken orally or by IV.
- ☐ Lab results and/or tests to support diagnosis.
  - Pre-Screening:
    - **Required lab results within 60 days: Calcium and Creatinine.** *Vitamin D only if patient is not on vitamin D replacement therapy.*
    - **Required lab results within 1 year**: **Vitamin D** *if patient is on vitamin D replacement therapy*
    - **Required bone density scan results within last 2 years**
- ☐ Please indicate name and direct phone number of a contact within your office that we can speak with to obtain any additional information:
  - Name: ___________________________
  - Phone Number: ______________________

Paperwork can be faxed or emailed to (843)-824-2327, infusionemail@articularishealthcare.com

Infusion Coordinators Brenna, Carlye or Stephanie will assist you with any questions at (843)-572-8932

Low Country Rheumatology Infusion Locations

Please mark preferred location and we will do our best to accommodate, however we cannot make any guarantees.

Summerville

2001 2nd Ave, Suite 201, Summerville, SC 29486

Mount Pleasant

1165 Chuck Dawley Blvd, Mt. Pleasant, SC 29464

West Ashley

2291 Henry Tecklenburg Drive, Charleston, SC 29414

Low Country Rheumatology Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our Infusion Coordinators will notify you if any further information is required. The patient will have an annual 30-minute consult with our MD to obtain H&P for chart. We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Thank you for the referral!

Low Country Rheumatology Use Only Existing Patient Yes____ No____ Physician ___________________

Updated December 3, 2018

Standard Orders for Reclast (zoledronic acid) Administration

Patient _______________________________________DOB_______________ Date__________

Indication:

☐ M81.0 Senile Osteoporosis without current fracture	☐ M85.89 Disorder of bone density	☐ Other ______________________________

History:

Does the patient have any upcoming or ongoing dental exams/procedures? ☐ Yes ☐ No

Patient must meet ONE of the following:

☐ Hip or vertebral fracture
☐ Other prior fractures and T-score between -1.0 and -2.5
☐ T-score ≥ -2.5 (after appropriate evaluation to exclude secondary causes)
☐ T-score between -1.0 and -2.5 and secondary causes associated with high fracture risk
☐ T-score between -1.0 and -2.5 WITH a 10-year probability of hip fracture ≥ 3% **or** 10-year probability of any major osteoporotic fracture ≥ 20%, based on FRAX assessment

Patient must have ONE of the following documented:

☐ Allergy to shellfish and/or salmon
☐ Intolerance of oral bisphosphonates due to medical or surgical conditions
☐ Noncompliance with oral bisphosphonate therapy for at least 3 months

Orders:

☐ Standard Order Protocol:

- Instruct patient on medication administration, possible side effects, and obtain signed consent form.
- Pre-medicate with 1000mg Acetaminophen PO TID on day of treatment.
- Verify that labs are current and within normal limits
- Verify that patient is on Ca+ and Vitamin D replacement therapy
- Baseline vitals will be obtained prior to administration, and at the end of the infusion (or hourly if infusion > 1 hour length until infusion is complete) and more frequently if patient's condition warrants it.
- **If infusion reaction occurs initiate infusion reaction protocol per Articularis Healthcare Policy and Procedure Manual.**
- Discharge instructions to include possible injection side effects and follow-up appointment schedule

Dose:

☐ Reclast 5mg/100ml IV administered over 30minutes x 1 dose

Labs:

☐ Confirm the following labs completed in the past 60 days if patient is not on vitamin D replacement therapy. If patient is on vitamin D replacement therapy, labs must be within 1 year and within normal limits: *attach copy of labs to order.*

NORMAL RANGE	Ca+ (8.4 – 10.5)	Vit D > 20	Creatinine Clearance > 35

Additional orders/comments:

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Practice Name: ______________________________

Physician Name: ___________________________________

Physician Signature: ________________________________

Date: ___________

NPI: ____

State License: _______________________________

DEA #: ______________________________________

UPIN: _______________________________________