



ZOLEDRONIC ACID ORDER FORM

(* - Required Fields)

 STAT REQUEST
(*REASON MUST BE PROVIDED BELOW)

 New Referral **Order Renewal** **Medication/Order Change**
 Benefits Verification Only **Discontinuation Order**

PATIENT INFORMATION

NAME*:	DOB*:	SEX: M F
ADDRESS:	PHONE:	
WEIGHT: LBS KG	HEIGHT:	EMAIL:
ALLERGIES:		

PHYSICIAN INFORMATION

PHYSICIAN NAME*:	PRACTICE NAME:
ADDRESS:	OFFICE CONTACT*:
PHONE: FAX:	EMAIL (FOR UPDATES):

ZOLEDRONIC ACID ORDER*: ICD-10*: _____
(SELECT ONE OF THE FOLLOWING)

 Dosing: 5mg IV every year(s)

Patient is currently taking Calcium/Vitamin D Supplement: Yes No

Physician Signature* _____ Date*(Order is Valid for One Year) _____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

 Osteoporosis
 Osteoporosis Postmenopausal
 Glucocorticoid-induced Osteoporosis
 Paget's Disease
 Osteopenia/Prevention of Osteoporosis
 Other _____

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

 Patient Demographics
 Insurance Card/Information
 Clinical/Progress Notes supporting DX
 Current Medication List and H&P
 Serum Calcium (w/in 12 months)
 DEXA Results
 Creatinine (w/in 12 months)

Last Infusion/Injection Date: _____

STANDING LAB ORDERS: CMP CBC
 Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

Locations:

-----Colorado-----
 Lakewood

-----Florida-----
 Jacksonville
 Kissimmee
 Port St. Lucie
 Suncoast
 Winter Park

-----Oklahoma-----
 Tulsa

-----Texas-----
 Arlington
 Cedar Hill
 Dallas
 Denton
 Ft. Worth
 Irving
 Rockwall
 Southlake
 Flower Mound
 Plano
 Tyler

REVISION DATE- 10/2021