



Checklist for Zoledronic Acid Referral

Patient Name: _____ DOB: _____ Date: _____

Referring Physician: _____ NPI: _____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- Patient demographic information
- Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- Supporting clinical notes and office visits. Two notes preferred.
 - Note should include any therapies tried/failed, and must include discussion about Zoledronic Acid
 - Medication list and allergies
- Supporting lab reports/imaging for Zoledronic Acid treatment
 - Baseline Calcium, BUN/Cr, and Vitamin D levels
 - Continued monitoring of Calcium, BUN/Cr, and Vitamin D prior to each treatment
 - Bone density report
- Zoledronic Acid Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible --

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 ext. 112

Visit our website: www.InfusionCenterNE.com

Email: info@infusioncenterne.com

Infusion Center of New England

9 Payson Road, Suite 100, Foxboro MA 02035

Ph: 781-551-5812

Fax: 508-698-8671



Prescribing Order: Zoledronic Acid

Date of Order: _____

New Start Maintenance

Date of last injection: _____

Patient Name: _____ DOB: _____ M/F: _____

Diagnosis (include ICD-10 code/s): _____

NKDA Allergies: _____

Premedication:

Acetaminophen 1000mg PO

Diphenhydramine 25mg PO

Loratadine 10mg or Cetirizine 10mg PO

Other: _____

Zoledronic Acid Medication Order : valid for 1 year

Medication: Zoledronic Acid 5mg/100ml IV once every 12 months

Preferred Product: _____

Administration:

- ✓ Administer
 Zoledronic Acid IV solution over 30 minutes
- ✓ In case of reaction, follow ICNE infusion reaction protocol. Notify physician.

Ordering Provider Name

NPI

Signature

Date