INFUSION CENTER OF NEW ENGLAND

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
☐ Loratadine 10mg or Cetirizine 10mg PO
☐ Diphenhydramine 25mg 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**

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671