Updated September 17, 2019

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.
- ☐ Is the patient on vitamin D and calcium supplementation? _____
- ☐ Lab results and/or tests to support diagnosis.
  - Pre-Screening:
    - **Required lab results within 60 days: Calcium, Creatinine, Vitamin D**
    - **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 (404)528-1852, argpriorauth@articularishealthcare.com

Arthritis & Rheumatology of GA
Prior Authorization Department will assist you with any questions at
(404)255-5956 extension:910

Arthritis & Rheumatology of GA services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our Prior Authorization Department will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Thank you for the referral!

Arthritis & Rheumatology of GA Use Only Existing Patient Yes____ No____ Physician _____

Updated September 17, 2019

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:

_____

_____

Practice Name: _____

Physician Name: _____

Physician Signature: _____

Date: _____

NPI: _____

State License: _____

DEA #: _____

UPIN: _____