Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Reclast® (zoledronic Acid) Infusion Order (10/16/2025)

All orders with a √ will be placed.

Patient Demographics:		
Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list) ☐ NKDA		

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)	
☐ M81.0 - Age-related osteoporosis without current fractures	☐ M89.9 - Disorder of bone, unspecified
☐ M81.8 - Other osteoporosis without current fracture	☐ M94.9 - Disorder of cartilage, unspecified
☐ M88 - Paget's disease	☐ Z92.241 - History of systemic steroid therapy (**SECONDARY**)
☐ Z79.52 - Long term use of systemic steroids (**SECONDARY**)	☐ Other:

Required Documentation: (*required prior to scheduling*)	
Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:
☑ Required Lab Results: Calcium and Creatine wihtin 3 months PRIOR to treatment (**Fax labs with order**)
☑ Hold treatment and notify provider IF: - Calcium is LESS THAN normal; - Creatinine clearance LESS THAN 35mL/min

Nursing Communication:
☑ Obtain vital signs PRE-treatment and POST-treatment. Obtain vital signs PRN during treatment.
☑ Assess for recent implants, root canals, or invasive dental work. Notify provider if patient has had recent invasive dental work.
☑ Monitor patient for signs of reaction for 30mins AFTER completion of 1st infusion and subsequent infusions PRN if previous signs of reaction observed.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)
☐ Acetaminophen (Tylenol) 1000mg PO ONCE unless taken at home

Infusion Therapy:
☑ Zoledronic acid (Reclast) 5mg IV over 15 minutes every 52 weeks

Hypersensitivity Protocol:
☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:	
Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted	
Signature:	Date: