INTRAMED Plus
infusion services

ZOLEDRONIC ACID

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Age-related Osteoporosis without current fractures — ICD-10 Code: M81.0
_____ Other Osteoporosis without current fracture — ICD-10 Code: M81.8
_____ Paget's disease — ICD-10 Code: M88.___
_____ Other:_____ — ICD-10 Code: _____

Allergies:_____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
  - Baseline Assessment, MD Progress/Visit Note
  - Evidence of previous fractures or clinical documentation of fracture risk (i.e. Dexa scan, documented T scores, etc.)
  - Patient Allergies
  - Labs – including serum creatinine and serum calcium

Patient
Weight: _____ lbs.
Height: _____ in.

ZOLEDRONIC ACID

J Code: J3489

4. Drug Order:

Zoledronic acid

Administer ____ mg intravenously

Pre-Medication Orders:

_____

No pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written — Substitution permitted

Printed Physician's Name:_____ Contact Phone #: _____

FAX ALL INFORMATION	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	COLUMBIA CHARLESTON GREENVILLE
ALTERNATE FAX 803.999.1887	CENTRAL INTAKE PHONE 800.767.6337