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 **CENTRAL FAX 803.794.0404**	**INFUSION CENTER LOCATIONS** **COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 800.767.6337**

APR 2022