

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 803.999.1754 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1960
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