Zometa (zoledronic acid)

Order Form
Rev. 4/10/2023

Infusion ASSOCIATES
Phone: (833) 394-0600
Fax: (833) 996-4888

PATIENT INFORMATION **Referral Status:** ◉ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description *(required)*:

☐ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to IA.

The patient has an existing prior authorization: ◉ Yes *(please fax IA a copy)* ◉ No *(IA will process for you)*

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

CLINICAL HISTORY

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug & Dose	Dates of Use	Drug & Dose	Dates of Use

Baseline serum calcium required prior to initiation of treatment and periodically during therapy:

Date of result: _____ Serum calcium level: _____

Serum creatinine required prior to EVERY dose. *Please fax serum creatinine results to (833) 996-4888.*

Not recommended in patients with hypocalcemia or creatinine clearance <30mL/min

PRE-MEDICATION ORDERS

Acetaminophen 650 mg PO given prior to every dose per IA protocol.

THERAPY ADMINISTRATION

Zometa (zoledronic acid) IV

Dose: 4 mg **Pharmacist to adjust dose based on creatinine clearance**

Frequency: ○ Once ○ Every _____ weeks

Total number of doses: _____

Date of last infusion if not at IA: _____ RX Expiration Date: _____

Additional Notes from Referring Office:

_____ _____ _____

Provider Name (Print) **Provider Signature** **Date**