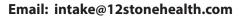
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





ZOLEDRONIC ACID ORDER FORM					
Date:	ICD-10 Code:	ICD-10 Code:		Therapy Status	
Patient Name:	Allergies:	Allergies:		☐ New Start	
Date of Birth:	Weight:lbs OR	kg		Continuing Therapy: Last Dose:	
PROVIDER INFORMATION					
Ordering Provider	Provider Fax:				
Provider NPI:		Provider Address:			
Provider Phone:					
MEDICATION ORDER					
	minutes x one dose		Please include the following lab results required for infusion. If no results are available, the following will be drawn prior to the first infusion:		
Zoledronic Acid	Prescriber Consideration ✓ Hypocalcemia may worsen during treatment. Then adequately supplement with calcium and vitamin E	cemia may worsen during treatment. Therefore, patients shou		□ Serum calcium within 60 days prior to each dose □ Serum creatinine within 60 days prior to each dose	
	exam prior to treatment.				
	 Contraindicated in patients with CrCl less than 35mL/min and in those evidence of acute renal impairment. 		se with		
PRE-MEDICATIONS					
ORAL □ Acetaminophen:325mg500mg650mg		IV Suppose the same of the sam			
□ Loratadine: 10mg		□ Dexamethasone:4mg8mg			
☐ Cetirizine: 10mg		☐ Diphenhydramine:25mg50mg ☐ Famotidine:20mg40mg			
□ Diphenhydramine:25mg50mg		☐ Methylprednisolone: 125mg			
□ Famotidine:20mg40mg		☐ Hydrocortisone: 100mg			
☐ Ibuprofen: 200mg400mg600mg		□ Ondansetron:4mg8mg			
□ Ondansetron:	Ondansetron:4mg 8mg				
Other:					
LAB ORDERS (please indicate any labs to be drawn and frequency)		OTHER REQUIRED DOCUMENTATION			
		(Please fax this signed order form, along with the following documents to 800-223-4063)			
	History & Physical, Last Office Visit Note Patient Demographics and Insurance Information				
**Surveillance lab orde	Medication List				
Surveillance lab ordering and monitoring is the responsibility of the prescriber • Recent Lab Work By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)					
By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.					
Dispense as Written:		Substitution Allowed:			
Prescriber Signature	nature Date Prescriber Signature		ature	 Date	