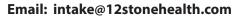
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





ZOLEDRONIC ACID ORDER FORM					
Date:	ICD-10 Code:	;D-10 Code:		Therapy Status	
Patient Name:	Allergies:	Allergies:		☐ New Start	
Date of Birth:	Weight:lbs OR	Weight: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		
Zoledronic Acid		Prescriber Considerations:  ocalcemia may worsen during treatment. Therefore, patients should quately supplement with calcium and vitamin D.		prior to the first infusion:  □ Serum calcium within 60 days prior	
	<ul> <li>Due to risk of osteonecrosis of the jaw, prescriber exam prior to treatment.</li> </ul>	o risk of osteonecrosis of the jaw, prescriber should perform ro prior to treatment.		to each dose  ☐ Serum creatinine within 60 days prior to each dose	
	<ul> <li>Contraindicated in patients with CrCl less than 35mL/min and in those evidence of acute renal impairment.</li> </ul>		se with	to each dose	
PRE-MEDICATIONS					
<u>ORAL</u> □ Acetaminophen:325mg500mg650mg		<u>/V</u> □ Dexamethasone:4mg8mg			
□ Loratadine: 10mg		□ Diphenhydramine:50mg			
□ Cetirizine: 10mg		☐ Famotidine:20mg40mg			
□ Diphenhydramine:25mg50mg		☐ Methylprednisolone: 125mg			
□ Famotidine:20mg40mg		☐ Hydrocortisone: 100mg			
□ Ibuprofen: 200mg400mg600mg		□ Ondansetron:4mg8mg			
☐ Ondansetron: ☐  Other:	4mg 8mg	□ Other:—			
LAB ORDERS	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 ordering and monitoring is the responsibility of the prescriber**  • Medication List • 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 Name	Date Prescriber Name		ne	 Date	