HOA
Hematology-Oncology Associates of CNY

Conveniently Located in East Syracuse, Camillus & Auburn
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

Patient Name:

Date of Birth: Height (inches): Weight (lbs):

Zoledronic Acid (Reclast)

Non-Oncology Treatment Order Set

Drug order form is valid for 12-months

Please complete *all fields* to facilitate timely intake and prior authorization processing

1. Diagnosis *MUST match recent office visit note*

If diagnosis and prescribed treatment are not addressed in a progress note (within 3-months), please include an addendum or letter of medical necessity.

M81.0 - Osteoporosis

M85.8 - Osteopenia

Other ICD-10: Description:

2. Pre-medications

Pre-medication:

No pre-medication indicated

3. Drug Order - Drug/Dose/Frequency:

Reclast 5mg IV every 12 months (Osteoporosis)

Reclast 5 mg every 24 months (Osteopenia)

Other:

Therapy Status

NEW to therapy

Continuing therapy: **Last dose received**: **Next dose due:**

Dental Clearance

Please note that any invasive dental work or tooth-related pain reported to HOA of CNY staff prior to initiation or subsequent therapies may result in therapy delays until further direction of the prescribing physician.

Okay to proceed *without* dental clearance.

Okay to proceed; dental clearance has been obtained. Date:
Please attach copy of clearance

Is the patient on **Calcium** & **Vitamin D** replacement? **YES** **NO**

Has patient trialed an **oral bisphosphonate**? **YES** **NO**

If yes, drug trialed:

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4. Required Labs

CMP within 30-days of infusion.

Other:

No lab monitoring indicated.

HOACNY **WILL NOT** DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.
The **prescribing physician** is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

INFUSION-LAB PARAMETERS
Our policy is to administer this medication as long as calcium and renal function (BUN, Creatinine and GFR) are within normal limits. If any additional monitoring parameters are required, please specify below:

5. Baseline labs / tests that have been completed

CMP

None

Dexa Scan (within 2-years)

POLICY ACKNOWLEDGEMENT

To maintain ongoing authorization, updated clinical documentation is required every 6-months and a new drug order form is required annually. Updated documentation will be required for all dose and/or frequency changes.

HOACNY will obtain authorization for drug administration prior to scheduled infusion. If HOACNY is unable to obtain insurance authorization due to this medication not being in alignment with the insurance plan's medical policy, the referring office with be notified and HOACNY will not be able to administer the medication. HOACNY may use a biosimilar or generic medication based on insurance company's preferred biosimilar medications or practice preferred medications. The biosimilar medication used may change during the course of treatment depending on those preferences. HOACNY does not participate in free drug programs.

HOACNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation and management of hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. The prescribing physician is responsible for educating the patient of potential risks and complications associated with the drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Medication Infusion Services referral. The prescribing provider is responsible for identifying and managing any side effects of the prescribed medication and for determining whether it is appropriate to proceed with treatment. Please call our office to coordinate with our Infusion Services Nurse Navigator, as appropriate. Any changes in condition or delayed adverse events that occur after leaving the infusion center will be reported to the prescribing physician for evaluation & management.

Provider's Name: Phone:

Provider's Signature: Date:

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Dental Clearance for Drug Administration

Patient Name:

Date of Birth:

Prescribing Physician:

Prescribing Physician's Phone #:

The above mentioned patient requires therapy with the following medication, under my supervision:

Zometa	Prolia
Xgeva	Boniva
Aredia	Evenity
Reclast	

Please evaluate the patient for clearance or any other recommendations following your exam.

The patient may need follow up dental/jaw exams every six months.

Please fax this form back, with your comments, to my office at Fax #:

Dental Clearance APPROVED

Dental Clearance DENIED

Comments & Recommendations:

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Treating Dentist: **Date:**

Dentist Signature: