TriState Health

RECLAST/PROLIA REFERRAL FORM

Patient Name* _____ Date of Birth* ____/____/_____

Patient Phone # _____ Primary Insurace Plan* _____

Diagnosis* _____ ❑ Male ❑ Female

❑ Please Administer RECLAST (Zoledronic Acid) 5mg/100ml x 1 dose

Accurate Height _____ Accurate Weight_____

Serum Creatinine _____ Date ____/____/_____

Serum Calcium _____ Date ____/____/_____

❑ *TriState Health Pharmacy will calculate Creatinine Clearance. Labs must be current within 30 days of the infusion date. P.O.C.3 prior to infusion, if indicated.*

❑ Please Administer PROLIA (Denosumab) 60mg sub-cutaneous every 6 months

---

Has patient started calcium/vitamin D? ❑ Yes ❑ No

Remind patient to drink 2 glasses of H2O during infusion.

From the physician office of _____

_____ _____ Date ____/____/_____

Print Name of Physician* Physician Signature*

After the above results are reviewed and an authorization is processed with the insurance company, TriState Outpatient Services will call the patient to schedule an appointment time.

TRISTATE OUTPATIENT SERVICES
PHONE: 509.758.4663
FAX: 509.751.0236

**All sections marked MUST be completed or the order form will be returned.*