

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

Patient Phone # _____ Primary Insurance 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) or BILDYOS (denosumab-nxxp) 60mg sub-cutaneous every 6 months
*(please circle one medication)*Has patient started calcium/vitamin D? Yes No**Remind patient to drink 2 glasses of H2O during infusion.**

From the physician office of _____

Print Name of Physician* Physician Signature* Date ____/____/____

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.*