



## Reclast Order Form

Select patient referral location:  Blue Ash  Worthington  Crestview Hills  Springfield  West Cincinnati  
Fax completed form to 888-977-0914. For new referrals, please include recent labs and last two office visit notes.

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

### 1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

### 2. PHYSICIAN INFORMATION

Physician's name:	NPI#:	
License #: <input type="text"/>	TIN#: <input type="text"/>	
DEA#: <input type="text"/>		
Address: <input type="text"/>		
City: <input type="text"/>	State: <input type="text"/>	Zip: <input type="text"/>
Office contact: <input type="text"/>	Email: <input type="text"/>	
Office phone: <input type="text"/>	Office fax: <input type="text"/>	

### 3. DIAGNOSIS INFORMATION (and year of diagnosis)

Osteoporosis  Paget's Disease  ICD 10 (  )  Other (specify):

### 4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

### 5. PRESCRIPTION INFORMATION (requires new order every 12 months)

#### RECLAST

- Administer 5 mg IV once a year
- Vital signs per HI Protocol
- Anaphylaxis & Hydration Management per HI Protocol

#### PRE-MEDICATIONS N/A

- Acetaminophen  500mg  650mg  1000mg PO
- Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
- Diphenhydramine (Benadryl)  25mg  50mg  PO  IV (requires driver)
- Methylprednisolone (Solu-Medrol)  40mg  80mg  125mg IV
- Prednisone  mg PO
- Other:

#### POST-MEDICATIONS N/A

- Acetaminophen  500mg  650mg  1000mg PO
- Prednisone  mg PO
- Other:

### 6. LABS

- |                                        |                                        |                                                                          |
|----------------------------------------|----------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> CBC w/Diff    | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): <input type="text"/> |
| <input type="checkbox"/> CRP           | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): <input type="text"/> |
| <input type="checkbox"/> CMP           | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): <input type="text"/> |
| <input type="checkbox"/> ESR           | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): <input type="text"/> |
| <input type="checkbox"/> Hepatic Panel | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): <input type="text"/> |
| <input type="checkbox"/> Renal Panel   | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): <input type="text"/> |
- Quantiferon TB Gold, annually, last completed (date):
- Other (specify):

### 7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE