CoxHealth a	at Home
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**RECLAST**<sup>®</sup>

CoxHealth	(zoledro	onic acid)	Fax: 1-417-269-0692
Patient Information		Prescriber	
Name:	DOB:	Prescriber name:	
Height: 🗅 in 🗅 cm	Weight 🛛 kg 🖵 lbs	NPI:	
Address:			
City: St	ate:Zip:	 City:	State:Zip:
Phone:Alte	rnate:	Contact:	
SSN:		Phone:	Fax:
PLEASE INCLUDE ON FA AND BACK OF INSU	JRANCE CARD(S)		
Clinical Information (Ple Diagnosis:  M81.0 (Osteoporos			
Allergies:			
Intravenous RECLAST®			
Flushing/Premedication Orders:			
✓ Flushing per CoxHealth at Hor	me protocol		
✓ PIV: 0.9% sodium ch	loride 3-20mL before and after	infusion as needed	
	hloride 3-20mL into port at time on as needed, Heparin 100 unit		nonthly, 0.9% sodium chloride 3-20mL be- infusion
✓ Following infusion, flush line with 30mL of 0.9% sodium chloride			
✓ No routine premedication needed	cessary. If desired, please write	here:	
RECLAST <sup>®</sup> (zoledronic acid) IV ove	er at least 15 min		
Frequency: Every 12 months. If d	ifferent frequency is desired, p	lease write here:	
Dose: 5mg (May administer pre-r	nixed solution or dilute in 100n	nL 0.9% sodium chlorid	e)
Quantity to dispense: 1 dose (1 y	ear) or 🗖infusion(s)		
Labs: every (freq	uency) 🗖 Calcium 🗖 Other:		
Prescriber's Signature:			Date
I authorize CoxHealth at Home and its representatives to act a stand that I can revoke this designation at any time by providir		thorization process for this prescription an	d any future fills of the same prescription for the patient listed above. I under-

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