

Infusion Order Form

Patient Information:

Patient Name

DOB

Phone Number

Medical Information:

Primary Diagnosis:

☐ Age-related Osteoporosis without current fracture

ICD-10 Code: M81.0

☐ Age-related Osteoporosis with current fracture

ICD-10 Code: M80.0

☐ Other _____

ICD-10 Code: _____

Allergies: _____ (or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
 - Currently receiving Calcium/Vitamin D supplementation:
 - ☐ Yes ☐ No ☐ Other: _____
- Required Information:
 - DXA scan within 2 years
 - Recent serum calcium and eGFR within 3 months

Height: _____

Weight: _____

Zoledronic Acid Orders:

☐ Administer 5 mg intravenously once

☐ 0.9% Sodium Chloride 250 mL IV prior to infusion

Pre-Medication Orders:

☐ Acetaminophen 650 mg PO

☐ Diphenhydramine 50 mg PO

☐ Loratadine 10 mg PO

☐ Cetirizine 10 mg PO

☐ Other: _____

Lab Orders: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

Prescriber's Signature

Date

Prescriber's Printed Name

Contact Phone #:

For Information About Revitalize and or Infusion Plus, please scan the QR code below:



Revitalize



Revitalize Locations



InfusionPlus

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