Nevada Infusion
Infusion Location (Pick one):
◯ **Reno** | ◯ **Sparks** | ◯ **Carson City** | ◯ **Las Vegas**
PH: 775-453-0667 | Fax: 775-470-8478

Reclast Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Age-related osteoporosis without current pathological fracture (ICD-10:M81.0)
- ☐ Other osteoporosis without current pathological fracture (ICD-10 Code: M81.8)
- ☐ Age-Related Osteoporosis with current pathological fracture (ICD-10 code: M80.0_____)** Complete code**
- ☐ Adverse effect of glucocorticoids and synthetic analogues ICD-10: T38.0X5A
- ☐ Other:_____ICD-10 Code:_____

ORDERS FOR RECLAST (Zoledronic Acid):

- ☑ **Reclast 5 mg/100 mL Intravenously once per year, x 1 year**

**** LABS: CMP Prior to Infusion****
Fax Results to: 775-470-8478

Additional Hydration (Optional):

- ☐ 500 ml NaCl 0.9%

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion

Lab Orders: _____
Fax results to: _____

PROVIDER INFORMATION:
Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Revised:11/2026

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◯ Reno | ◯ Sparks | ◯ Carson City | ◯ Las Vegas
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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Supporting documentation to include past tried and/or failed therapies

Additional REQUIRED Information:

☐ Serum Ca levels

☐ Creatinine clearance and serum creatinine prior to each dose

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Revised: 11/2026