Edward-Elmhurst Cancer Centers
120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/646-2273 Fax: 630/548-6617

24600 W. 127th Street; Plainfield, IL 60585
Phone: 630/646-2273 Fax: 630/548-6617

177 E. Brush Hill Road; Elmhurst, IL 60126
Phone: 630/646-2273 Fax: 331/221-3887

Reclast Infusion Therapy Orders

Patient Name: _____ DOB: _____

*****Please include current history and physical and any recent labs/tests, if applicable*****

PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

Pre-Authorization # or Call Reference #: _____

(Ordering Physician Office is Responsible to Obtain Authorization/Referral)

☐ **Check if insurance requires drug to be provided by specialty pharmacy**

Contact Name and Phone Number of Insurance Company: _____

If you have any questions regarding pre-authorizations, please contact (630) 527-3788 and ask for the billing department.

Patient's Weight: _____

PRIMARY DIAGNOSIS (ICD-10 REQUIRED): _____

SECONDARY DIAGNOSIS (ICD -10 REQUIRED): _____
(The following dx codes do not require secondary diagnosis: M88.9; M81.0; M84.453A)

Pre-Infusion Requirements:

This patient has a calculated creatinine clearance of greater than or equal to 35ml per minute and a normal serum calcium level **(labs must be done within 1 month of infusion)** ☐ **Yes** ☐ **No**

Date of Lab Results (PLEASE ATTACH COPY): _____

Required lab work prior to Reclast may be done at Cancer Center on day of infusion ☐ **Yes** ☐ **No**

Patient currently taking calcium and Vitamin D supplements ☐ **Yes** ☐ **No**

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Dosing Guidelines:

☐ Senile Osteoporosis: Reclast 5mg IVPB over 20 minutes once yearly.

☐ Paget's Disease Reclast 5mg once yearly or as determined

In the event of a hypersensitivity reaction during the infusion of this medication, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient and your office will receive notification of the event.

In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.

Physician Signature: _____ **Date:** _____

Ordering Physician NPI: _____ **Swedish Hospital NPI:** **1831151257**

Physician Name (Please Print)	**Office Phone**	**Fax Number**

Revision/Review Date: 12/2024