HUNT REGIONAL INFUSION CLINIC
PHONE: 903-408-5840
FAX: 903-455-8773

RECLAST
ORDER FORM

PATIENT INFORMATION

Last Name:_____First Name:_____MI_____
HT:_____ WT:_____ DOB:_____ SEX:_____ SSN:_____
Street Address:_____City/State/Zip:_____
Home Phone:_____ Work Phone:_____ Cell:_____
Allergies:_____

INSURANCE INFORMATION

Primary Insurance Name:_____ Policy #:_____
Secondary Insurance Name: _____ Policy #:_____

PHYSICIAN/FACILITY INFORMATION

Physician's Name:_____Contact Name:_____Contact Phone:_____
Street Address:_____City/State/Zip:_____
DEA #:_____ NPI #:_____ FAX:_____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____

Date of Diagnosis: _____
Does the patient have venous access? O Yes O No If Yes, what type? _
_____
If No, does patient need venous access? O Yes O No If Yes, please specify in the prescription orders.

PRESCRIPTION ORDERS:

RECLAST 5MG, IV
TO BE INFUSED ONCE A YEAR OVER 20 MINUTES
INCLUDE COPIES OF BUN/CREATININE LABS WITHIN 30 DAYS
OTHERWISE, A BUN/CREATININE WILL BE DRAWN PRIOR TO INJECTION

_____

"Pharmacy law may permit pharmacists to substitute a less expensive FDA-approved generically equivalent medication or biosimilar for a brand-name medication or prescribed biologic unless the practitioner indicates otherwise by writing "brand necessary" or "brand medically necessary" on the prescription."

☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT –**

UNLESS THE BOX IS CHECKED ALL PICC LINES, MIDLINES, AND CENTRAL LINES MAY BE FLUSHED WITH *HEPARIN 300unit/3mL*

Physician's Signature _____Date:_____ Time:_____

Fax completed form to Hunt Regional Infusion Center at (903) 455-8773. PLEASE include copies of ALL patients' current insurance cards to expedite benefit verification. Also forward any lab work, Letter of Medical Necessity and any other supporting documentation supporting the use of Infusion Therapy.