TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

ZOLEDRONIC ACID (Reclast® Generic)

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
City, State, Zip: _____
Plan #: _____
Group #: _____
Phone: _____

RX Card (PBM): _____
BIN: _____ PCN: _____
City, State, Zip: _____
Group #: _____
Phone: _____

Secondary Insurance (If Applicable):

Secondary Insurance: _____
Plan #: _____
Phone: _____

City, State, Zip: _____
Group #: _____

CLINICAL INFORMATION

☐ M81.8 Osteoporosis, unspecified ☐ M81.00 Osteoporosis without pathological fracture ☐ Other (specify ICD-10):_____
T-Score (If known): _____
History of osteoporotic fracture? ☐ Yes ☐ No Skeletal Site (If known): _____
Has the patient failed or is unable to tolerate bisphosphonate therapy? ☐Yes ☐ No
↳ If yes, please explain: _____
Does the patient have >1 risk factor for fracture? ☐ Yes ☐ No
↳ If yes, please explain: _____
Reason for discontinuing previous osteoporosis therapies: _____

ZOLEDRONIC ACID ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Infusion/Injection: _____

Medication	Dose/Frequency	Refills
☐ Zoledronic Acid (Reclast Generic)	☐ Infuse 5mg IV once a year ☐ Other: _____	Refills: _____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____
Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.