



Reclast Order Form

Select patient referral location: Anchorage Palmer Fairbanks

Please fax or securely email to 1-907-921-7669 or RX@luxinfusion.com.
 For new referrals, please **include recent labs and last two office visit notes.**
 Clinic Phone Number: 1-907-744-1944 · luxinfusion.com

1. PATIENT INFORMATION

Name:		DOB:	
Home phone:		Other phone:	
Email:			
Social Security #:		Allergies:	
Gender:	M F	Weight:	
Patient Status:	New to therapy	Continuing therapy	Next due date (if applicable):

2. PHYSICIAN INFORMATION

Physician's Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State:	Zip:
Office contact:		Email:	
Office phone:		Office fax:	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

Osteoporosis Paget's Disease ICD 10 (_____) Other (specify): _____

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

RECLAST	PRE-MEDICATIONS	N/A
Administer 5 mg IV once a year	Acetaminophen 500mg 650mg 1000mg PO	
	Cetirizine (Zyrtec) 10mg PO (or other non-sedating anti-histamine)	
	Diphenhydramine (Benadryl) 25mg 50mg	
		PO IV (requires driver)
Vital signs per LUX Protocol	Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV	
Anaphylaxis & Hydration Management per LUX Protocol	Prednisone _____ mg PO	
	Other: _____	
	POST-MEDICATIONS	N/A
	Acetaminophen 500mg 650mg 1000mg PO	
	Prednisone _____ mg PO	
	Other: _____	

6. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE