PIEDMONT ARTHRITIS CLINIC, P.A.

RHEUMATOLOGY

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3 ST. FRANCIS DRIVE
SUITE 400
GREENVILLE, SC 29601
TELEPHONE: (864)-235-8396
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RECLAST INJECTION REFERRAL FORM

PATIENT INFORMATION LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ CITY: _____ ST _____ ZIP _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

PCP: _____ __ PCP PHONE #: _____PCP FAX #

_____

DOB: _____ SOCIAL SECURITY #: _____ EMPLOYER:

_____

INSURANCE: _____ INS. ID#: _____ RESP. PARTY:

_____

REFERRING PROVIDER: LAST NAME: _____ FIRST NAME: _____

□ MD □ DO □ NP UPIN# _____ NPI#

_____

ADDRESS: _____ CITY: _____ ST _____ ZIP _____

CONTACT NAME: _____ PHONE #: _____ FAX #_____

HISTORY:

To be eligible for Reclast coverage, patients must be postmenopausal women and men age 50 and older presenting with one of the following criteria set forth by the National Osteoporosis Foundation: (**Please check appropriate box**)

□ A hip or vertebral (clinical or morphometric) fracture, OR

□ Other prior fractures and low bone mass (T-score between -1.0 and -2.5 at the femoral neck, total hip or spine), OR

□ T-score ≤-2.5 at femoral neck, total hip or spine after appropriate evaluation to exclude secondary causes, OR

□ Low bone mass (T-score -1.0 to -2.5 at femoral neck, total hip or spine) and secondary causes associated with high risk of fracture (such as glucocorticoid use or total immobilization), OR

□ Low bone mass (T-score between -1.0 to -2.5 at femoral neck, hip or spine) with a 10-year probability of hip fracture ≥ 3% **or** 10-year probability of any major osteoporosis-related fracture of ≥ 20% based on the US-adapted WHO algorithm.

AND one of the following criteria:

□ Documented allergy to shellfish and/or salmon derivatives.

□ Documented intolerance of oral bisphosphonate therapy due to medical or surgical conditions including but not limited to: severe esophageal disease (e.g. ulcerations, strictures); esophageal symptoms or dysphagia severe enough to cause patient non-compliance with oral bisphonates; inability to take anything by mouth; inability to sit or stand for at least 30 minutes; or intestinal malabsorption.

AND

□Documented non-compliance with oral bisphosphonate treatment regimen of at least 3 months.

BONE MINERAL DENSITY DONE WITHIN PAST TWO YEARS? _____ T-SCORE_____

PRIMARY DIAGNOSIS: _____

IS THERE A PREFERENCE FOR TREATING PHYSICIAN? □ NO □ YES: _____

SERVICES REQUESTED:

□ EVAL AND TREAT WITH **RECLAST** INJECTION **ONLY**. □ BONE MINERAL DENSITY TEST

□ EVAL AND TREAT FOR OTHER **RHEUMATOLOGIC** CONDITION (DX: _____)

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PLEASE FAX THE FOLLOWING TO 864-271-4092

- ☐ THIS **COMPLETED** FORM
- ☐ COPY OF PATIENT'S INSURANCE CARD(S)
- ☐ APPLICABLE LAB AND/OR IMAGING TEST REPORTS
- ☐ APPLICABLE MEDICAL RECORDS

APPOINTMENT DATE, TIME AND DOCTOR: _____