Northwest Rheumatology Associates, P.C.
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RECLAST INFUSION PROTOCOL

Patient Name:_____DOB:_____Date_____

Patient demographics, (address, phone) ❒

Copy front and back of all insurance cards ❒

The dose of Reclast is 5mg/100ml in a ready to use bottle.

Prior to infusion confirm the following;

Completed	**Not required**	
☐	☐	**Creatinine clearance** has been checked within 6 months and is greater than or equal to 35ml/min
☐	☐	**Serum calcium** has been checked within 6 months and is within normal range
☐	☐	**Vitamin D** has been checked within 6 months and is greater than 30ng/ml
☐	☐	**Dental exam within 6 months of treatment**

Obtain IV access (use of saline lock recommended for infusion)
Prepare Reclast, open vent cap and prime tubing (using a vented line)
Infuse as a piggyback with .9% NS as primary fluid.
Flow Rate:
Begin flow rate at 100ml /hr
Infuse over one hour in effort to avoid flu-like symptoms.
Remove catheter
Discontinue catheter after each treatment.
Call physician with any infusion reactions.
Give patient discharge instructions

ICD-10 Code: _____

CPT Code: J3489

Ordering physician signature: _____

Ordering physician printed name: _____

Ordering physician phone number: _____

Ordering physician fax number: _____

Please note all boxes must be checked off for us to schedule your patient for treatment.
Please fax this information to (503) 297-0863 Attn: Patient Resource Team. Please call with any questions at (503) 297-3384