Palmetto Infusion Services COMPLIANCE

MRN:_____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB: _____

STANDARD ibandronate sodium (generic for Boniva®) PLAN OF TREATMENT

(Re) Certification Period From_____to _____

NOTE: Patient ***may be ineligible*** to receive ***ibandronate sodium*** if the patient's serum creatinine is greater than 2.3mg/dl. Injections may cause a decrease in serum calcium values. Treat hypocalcemia, hypovitaminosis D, and other disturbance of bone and mineral metabolism before starting ***ibandronate sodium*** therapy. Treatment will not be administered if the serum calcium is sub-therapeutic.

1. Patient Name: _____Height (inches): _____Weight (lbs):_____

2. Allergies: _____

3. DIAGNOSIS: ☐ M81.0 Age-related Osteoporosis without current fractures

☐ M80.___ Age-related Osteoporosis with fractures

☐ Other **ICD-10 code:** _____**Diagnosis description:**_____

4. History: Is the patient on Calcium and Vitamin D replacement? ☐ Yes ☐ No

(It is recommended that patients receive supplemental calcium and vitamin D if dietary intake is inadequate, treatment will not be administered if the serum calcium is sub-therapeutic.)

Orders: Obtain weight each visit. Vital signs at baseline, 15 minutes post injection, and then may discharge after each injection. Instruct patient/caregiver on medications and signs/symptoms of adverse reaction. Assess patient for response to therapy. Utilize existing central line for administration or initiate a peripheral IV with each infusion as needed. Sodium Chloride 0.9% flush 3-10 ml before, after, and as needed during the infusion. Follow infusion with Heparin 100 units/ml 1 – 5 ml per line type or to peripheral IV as required for multiple day treatments. Supplies needed to complete prescribed therapy. Pharmacist to perform clinical drug monitoring. ***If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES***

5. Dose/Frequency:

☐ Ibandronate sodium (generic for Boniva®) 3 mg IV push administration over 15-30 seconds every 3 months (no less than every 12 weeks)

☐ Special orders: _____

Lab Orders: BMP prior to each dose; if serum creatinine is greater than 2.3 mg/dl or if the serum calcium is sub-therapeutic, then ibandronate sodium administration will be held and the referring physician notified.

Pharmacist will perform clinical lab monitoring, results preferred within 30 days of each dose.

6. Physician's Signature: _____/ _____Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____

7. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms available at www.palmettoinfusion.com

Revised 6/1/2017

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DOB: _____

Guidelines for Prescribing STANDARD ibandronate sodium (generic for Boniva®)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-7)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results or bone scans to support diagnosis.**

- Ibandronate sodium (generic for Boniva®) is a bisphosphonate indicated for the treatment and prevention of postmenopausal osteoporosis.
- **Please include documentation regarding treatment history to include: Inadequate response or intolerance to oral bisphosphonates, presence or history of osteoporotic fractures, low bone mass (T-score more than 2.0 standard deviations below premenopausal mean; 2.5 for Medicare patients)**

___ If patient is switching bisphosphonate therapies, then MD must specify wash-out period prior to start of *Ibandronate sodium (Boniva®)* as specified of _____ weeks. Last known therapy: _____and last date received:_____.

___ Other as requested: _____
_____

Pre-Screening:

___ BMP results required within last 30 days

** **Warnings/Precautions:** Boniva® (ibandronate sodium) should not be administered more frequently than once every 3 months. • **Hypocalcemia:** can worsen, correct hypocalcemia prior to use. Adequately supplement patients with calcium and vitamin D • **Anaphylaxis:** including fatal events, has been reported. • **Renal Toxicity:** may be greater in patients with underlying renal impairment. Do not administer injection to patients with severe renal impairment (creatinine clearance less than 30 mL/min). Monitor serum creatinine prior to each dose. • ***Tissue Damage with Inappropriate Drug Administration can occur***. Boniva® (ibandronate sodium) injection must only be administered intravenously. Care must be taken not to administer injection intra-arterially or paravenously as this could lead to tissue damage. • **Osteonecrosis of the jaw (ONJ):** has been reported, perform a routine oral examination prior to administration. Consider a dental examination with appropriate preventive dentistry prior to treatment with bisphosphonates in patients with a history of concomitant risk factors (e.g., cancer, chemotherapy, angiogenesis inhibitors, radiotherapy, corticosteroids, poor oral hygiene, pre-existing dental disease or infection, anemia, coagulopathy). • **Severe Bone, Joint, and/or Muscle Pain:** consider discontinuing use if symptoms occur. • **Atypical Femur Fractures:** have been reported. Patients with new thigh or groin pain should be evaluated to rule out a femoral fracture. **Limitations of Use:** Optimal duration of use has not been determined. For patients at low-risk for fracture, consider drug discontinuation after 3 to 5 years of use. See full prescribing information

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.