MRN:_____

DOB: _____

STANDARD Ibandronate Sodium (generic for Boniva®) PLAN OF TREATMENT

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. Order:

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: _____

5. Clinical Lab Monitoring: ***Referring provider*** **to provide BMP results prior to each dose (preferred within 30-60 days);** 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. Injections may cause a decrease in serum calcium values. It is recommended that patients receive supplemental calcium and vitamin D if dietary intake is inadequate. Treat hypocalcemia, hypovitaminosis D, and other disturbance of bone and mineral metabolism before starting ***Ibandronate Sodium*** **t**herapy**.**

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

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

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

Printed Physician's Name with Credentials: _____

Revised 03/16/2021

MRN:_____

DOB: _____

Guidelines for Prescribing Ibandronate Sodium (generic for Boniva®)

(Required documentation with all initial referrals)

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

☐ Include signed and completed **Plan of Treatment**.

☐ 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 preferred within last 30-60 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

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.