Palmetto INFUSION®

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

Referral Status:	MRN:
☐ New referral ☐ Order change ☐ Order Renewal	
Patient preferred clinic:	

Boniva® (ibandronate sodium) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

- ☐ M81.0 - Age-related Osteoporosis without current fractures
- ☐ M80.___ - Age related Osteoporosis with fractures
- ☐ _____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	BMP results within last 30-60 days		☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive ibandronate sodium if serum creatinine is greater than 2.3mg/dl or is the serum calcium is sub-therapeutic.

DOSE/FREQUENCY:

- ☐ Ibandronate sodium (generic for Boniva®) 3 mg IV push administration over 5-30 seconds every 3 months (no less than every 12 weeks)
- ☐ Other:_____

SPECIAL ORDERS:

- ☐ _____

LAB PARAMETERS: (Pharmacist to perform clinical lab monitoring)

Serum Creatinine > 2.3mg/dl: dose will be held unless written clearance is provided by MD

Serum Calcium is below normal range: dose will be held unless written clearance is provided by MD

- ☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

- ☑ Start PIV/Access CVC
- ☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	