

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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:
<input type="checkbox"/> See list	<input type="checkbox"/> NDKA

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

<input type="checkbox"/> M81.0 - Age-related Osteoporosis without current fractures
<input type="checkbox"/> M80.____ - Age related Osteoporosis with fractures
<input type="checkbox"/> _____ - Other:

REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INJECTION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INJECTION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	BMP results within last 30-60 days	THERAPY:	
			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



Palmetto

INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- 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**

Palmetto Infusion 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com