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 ☐ NKDA

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:

REQUIRED 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 is less than 30 mg/mL or is the serum calcium is subtherapeutic. Pre-existing hypocalcemia must be corrected prior to initiating therapy. A routine oral exam is recommended to be performed by the prescriber prior to start of Ibandronate sodium treatment.

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 NEEDED PRIOR TO EACH DOSE:

Creatinine Clearance <30mg/mL: dose will be held unless written clearance is provided by MD

☐ Prescriber clearance waived for recent or planned dental procedures.

☑ Refills x 12 months unless noted otherwise here:

NURSING ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Start PIV/Access CVC ☑ Flush device per facility standard flushing procedure ☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.

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	