

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"/> NKDA

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:

REQUIRED 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 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:

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

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

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



Checklist for referrals to Palmetto Infusion: Fax referral to 1.800.521.9640

- 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com