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

# Boniva® (ibandronate sodium) Standard Plan of Treatment

Rev 4.25.25

## PATIENT DEMOGRAPHICS:

| | | | | | |
|---|---|---|---|---|---|
| Patient Name: | | | | | |
| Patient's Phone: | | 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<br>☑ Flush device per facility standard flushing procedure<br>☑ 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 | |

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 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