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| ADULT AMBULATORY INFUSION ORDER  **Ibandronate sodium (BONIVA) Injection** | **NAME:**  **BIRTHDATE:**      *Affix Patient Identification Label Here* |
| **ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (**  **) TO BE ACTIVE.** | |

**Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

\***Please fax a copy of the** □Demographics □ Insurance Information □ Current Lab Results

**following patient information**: □ H & P Relevant to Diagnosis □ Last infusion note □ Current Medications

Provider Information

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Information

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ lbs/kg Height: \_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

labs:

□ CMP □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Vitamin D 25 Hydroxy □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No labs needed

**BONIVA (ibandronate sodium) IV DOSAGE:**

**Dose: 3 mg IV bolus, over 15-30 seconds.**

**Frequency: Every 12 weeks for 4 treatments.**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

MC2696 (07/22)