Phone:616-954-0600 Fax: 616-954-1675

# Boniva IV

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

**Referral status:** ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

**Date**: _____/_____/_____

**Patient Name**: ________________________________________________ **DOB**: _____/_____/_____

**Allergies**: ___________________________ **Patient Weight:** ________lbs / kg **Height:**___________

**Diagnosis** : ☐ Osteoporosis, please specify ICD-10 code: ______________________________________
☐ Other: please specify:_______________________________________________________

Attach most recent DEXA scan results: Date:_______________________ T-Score: ___________________

In the past year, what medications for the above diagnosis has the patient tried and failed?
☐ N/A continuation of treatment

| Drug | Dose | Dates of use |
|---|---|---|
| | | |
| | | |

## **Boniva** (Ibandronic acid) **3mg IVPush**
### Every 3 months for a total of 4 doses per year

**Labs required within 2 months of appointment.**
**Result date: ____/_____/____**

**Serum Calcium: _____________**

**Serum Creatinine: ____________**

*Contraindicated in patients with hypocalcemia or creatinine clearance 35mL/min*

**Printed provider name**: ________________________________________________________________

**Provider signature**: ___________________________________________________________________

**Office phone number:** ____________________ **Fax number:** __________________________________