Infusion ASSOCIATES

Phone: (833) 394-0600 Fax: (833) 996-4888

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:_____

Is patient currently taking calcium and vitamin D? ☐ Yes ☐ No, reason for not taking_____

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?

Drug	Dose	Dates of use

Baseline serum calcium required prior to initiation of treatment and periodically during therapy
Date of result:_____ Serum Calcium level:_____

Serum creatinine required prior to EVERY dose
Please fax serum creatinine results prior to EVERY dose

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

Not recommended in patients with hypocalcemia or creatinine clearance <30mL/min

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____

Contact Name: _____**Contact Phone Number:** _____

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐ Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐ Other: _____