Conveniently Located in East Syracuse, Onondaga Hill & Auburn
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

Boniva (Ibandronate Sodium) Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ **Height (inches):** _____ **Weight (lbs):** _____

3. Diagnosis:

[ ] M81.0 Age-related osteoporosis without current fracture
[ ] Other ICD-10 Code: _____ Diagnosis description: _____

HOACNY will obtain authorization for drug administration prior to scheduled infusion. If HOACNY is unable to obtain insurance authorization due to this medication not being in alignment with the insurance plan's medical policy, referring office will be notified and HOACNY will not be able to administer the medication.

4. Pre-medications:

[ ] Other Pre-medication: _____
[ ] No Pre-medications indicated

5. Drug Order:

Boniva (Ibandronate sodium) *Ok to substitute with generic/biosimilar*

Dose/ Frequency:

[ ] **3mg IV push administration over 15-30 seconds every 12 weeks**
[ ] Other: _____

Dental Clearance:

[ ] Ok to proceed without dental clearance
[ ] Ok to proceed, dental clearance obtained, Date: _____ (copy of clearance attached)

[ ] New to Therapy
[ ] Continuing therapy: Last Dose Received _____ Next Dose Due _____

- Is the patient on Calcium & Vitamin D replacement? [ ] Yes [ ] No

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

[ ] CMP annually, hold if serum Calcium is sub-therapeutic
[ ] Other: _____
[ ] No lab monitoring indicated

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.
The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. **Required Baseline Lab/Testing have been completed**:

[ ] CMP, date: _____ [ ] DEXA Scan, date: _____ [ ] Other: _____ [ ] None

8. **Patient Assistance & REMS Program Enrollment**

[ ] Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)
[ ] No, patient has not been enrolled in any programs.

Physician's Name: _____ **Phone:** _____
Physician's Signature: _____**Date:** _____

(This drug administration order form is valid for 12 months)

Dental Clearance for Drug Administration

Patient Name: _____ DOB: _____
Prescribing MD: _____ Prescribing MD Phone Number: _____

The above mentioned patient requires therapy with the following medication, under my supervision:

_____Zometa

_____Xgeva

_____Aredia

_____Reclast

_____Prolia

_____ Boniva

_____ Evenity

Please evaluate the patient for clearance or any other recommendations following your exam.
The patient may need follow up dental/jaw exams every six months.

Please fax this form back, with your comments, to my office at (fax) _____.

[_] Dental Clearance APPROVED

[_] Dental Clearance DENIED.

See Comments and Recommendation Below:

_____

_____

_____

_____

Treating Dentist:_____

Dentist Signature:_____

Date:_____