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: _____

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.

7. **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:_____