Hematology-Oncology Associates of CNY

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

Patient Name: **Height** (inches):

Date of Birth: **Weight** (lbs):

Boniva (Ibandronate Sodium)

Non-Oncology Treatment Order Set
Drug order form is valid for 12-months

Please complete *all fields* to facilitate timely intake and prior authorization processing.

1. **DIAGNOSIS** *MUST match recent office visit note*
   Please include an addendum or letter of medical necessity, if appropriate.

   ☐ **M81.0** - Age-related osteoporosis without current fracture
   ☐ Other ICD-10 Code: Description:

   DIAGNOSIS DATE:

2. **PRE-MEDICATION**
   ☐ Other Pre-medication:
   ☐ No Pre-medications indicated

3. **DRUG ORDER**
   Boniva (Ibandronate Sodium)

   ☐ 3mg IV push administration over 15-30 seconds every 12 weeks
   ☐ Other:

   Therapy Status

   ☐ **NEW** to therapy

   ☐ **Continuing** therapy-
   Last dose received: Next dose due:

   ☐ Copy of *Medication Administration Record* is attached

   Drug-Specific Requirements *Fax all results to HOACNY*

   Dental Clearance

   Please note that any invasive dental work or tooth-related pain reported to HOA of CNY staff prior to initiation or subsequent therapies may result in therapy delays until further direction of the prescribing physician.

   ☐ Okay to proceed *without* dental clearance.
   ☐ Okay to proceed; dental clearance has been *obtained* (attach) - Date:

4. **REQUIRED LABS**
   ☐ CMP annually
   ☐ CMP Other Frequency:
   ☐ Serum creatinine *prior to each dose*
   ☐ Serum calcium *prior to each dose*
   ☐ None indicated

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****HOACNY 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.

5. **LAB-INFUSION PARAMETERS**
Our policy is to administer this medication as long as **calcium, renal function** (BUN, Creatinine), and **white blood cell** count are within normal limits. If any additional monitoring parameters are required, *please specify below*:

6. **COMPLETED BASELINE LABS & TESTS** ***Fax all results to HOACNY***
☐ CMP
☐ Dexa Scan
☐ Other:
☐ None

POLICY ACKNOWLEDGEMENT
To maintain ongoing authorization, updated clinical documentation is required every 6-months and a new drug order form is required annually. Updated documentation will be required for all dose and/or frequency changes.

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, the referring office with be notified and HOACNY will not be able to administer the medication. HOACNY may use a biosimilar or generic medication based on insurance company's preferred biosimilar medications or practice preferred medications. The biosimilar medication used may change during the course of treatment depending on those preferences. HOACNY does not participate in free drug programs.

HOACNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation and management of hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. The prescribing physician is responsible for educating the patient of potential risks and complications associated with the drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Medication Infusion Services referral. The prescribing provider is responsible for identifying and managing any side effects of the prescribed medication and for determining whether it is appropriate to proceed with treatment. Please call our office to coordinate with our Infusion Services Nurse Navigator, as appropriate. Any changes in condition or delayed adverse events that occur after leaving the infusion center will be reported to the prescribing physician for evaluation & management.

Provider's Name: **Phone**:

Provider's Signature: **Date**:

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Dental Clearance for Drug Administration

Patient Name:

Date of Birth:

Prescribing Physician:

Prescribing Physician's Phone #:

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**

Comments & Recommendations:

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_____

_____

_____

Treating Dentist: **Date:**

Dentist Signature:

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04-14-2026