

Patient Name: _____

Address: _____

Phone Number: _____ Date of Birth: _____ Age: _____ Weight: _____ KG

Diagnosis: Postmenopausal osteoporosis 733.01 CPT 96374 + pharmacy fee for drug

Allergies: _____

Physician's office fax #: _____

Fax to: Overlake Hospital Centralized Scheduling Center

Fax: (425) 688 – 5710

Phone: (425) 688 – 5700

Infusion Suite: (425) 688 – 3773 Third Floor, West Tower

Patient reports to admission desk in Overlake Hospital lobby

Date infusion is scheduled: _____ Time scheduled: _____

INFORMATION TO ACCOMPANY THIS ORDER:

• Primary and Secondary insurance information. Please copy front and back of card and fax along with this form. If unable to copy, please provide insurance name, phone number and policy #, group # and policy holder name

• Authorization from insurance company

If no authorization is required, please explain: _____

• Serum Creatinine lab results

• Copy of recent H & P including list of medications

PRE-SCREENING SAFETY ISSUES:

• Serum Creatinine must be normal

• Ibandronate (**Boniva**) will **NOT** be given if creatinine clearance measured or estimated GFR less than or equal to 35 mL/ minute

• Patient must be taking calcium and vitamin D supplements

• Labs must be done prior to IV administration (send with this order)

MEDICATION:

Ibandronate (Boniva) 3 mg IV push over 15 - 30 seconds X 1 (Code J 1740)	Osteoporosis
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Physician Signature

Date

Time

P H Y S I C I A N O R D E R



BONIVA INFUSION SUITE REFERRAL ORDERS

P0241A (Rev 0709)

White – Chart