



General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone # _____

Order Start Date _____ Order Expiration Date (*max one year*) _____

Allergies: _____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.
2. All patients should be prescribed daily calcium and vitamin D supplementation
3. Risk verses benefit regarding osteonecrosis of the jaw and hip fracture must be discussed prior to treatment.
4. A complete metabolic panel is recommended and a calcium level must be obtained within 30 days prior to starting treatment
5. The corrected calcium level should be greater than or equal to 8.4 mg/dL.
6. PROVIDER TO PHARMACIST COMMUNICATION - Creatinine clearance is calculated using CockcroftGault formula (Use actual weight unless patient is greater than 30% over ideal body weight, then use adjusted body weight). If serum creatinine below 0.7 mg/dL, use 0.7 mg/dL to calculate creatinine clearance. No dose adjustment required for CrCl greater than or equal to **30 mL/min**.
7. **Must complete and check the following box:**

Provider confirms that the patient has had a recent oral or dental evaluation and/or has no contraindications to therapy related to dental issues prior to initiating therapy.

DIAGNOSIS CODE: **IF using 'Other' must include ICD10 code**

- M81.0 Postmenopausal Osteoporosis
- Other: _____

Nursing Orders

- If no results in the past 30 days, order CMP.
- Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.
- Remind patient to take at least 500 mg elemental calcium twice daily and 400 units vitamin D daily.
- Vital Signs: baseline and at discharge. Hold patient for 15 minutes post-administration to observe/monitor for adverse reaction

Medication Orders

- Boniva (ibandronate) 3mg IVP, over 15 to 30 seconds, every 12 weeks for 4 treatments.

IF HYPERSENSITIVITY OR ANAPHYLACTIC REACTION OCCURS

- Notify provider and/or Hospitalist on duty if afterhours, administer oxygen prn, administer Benadryl 50 mg IV or IM once STAT, administer Epinephrine (1:1000) 0.5mg IM once STAT, possible admission to emergency department for further evaluation/treatment.

<p><i>Patient Name:</i></p> <p><i>DOB:</i></p>
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Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patient identified on this form.

I hold an active, unrestricted license to practice medicine in _____ (*specify state*)

My physician license number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medication described above for the patient identified on this form.

Provider Signature: _____	Date _____
Printed name: _____	Phone: _____
Fax: _____	

KVH Provider Co-signature: <i>*Required for all external orders</i>	
Provider Signature: _____	Date _____
Printed name: _____	

<i>Patient Name:</i>
<i>DOB:</i>