Outpatient Boniva (ibandronate) Order Set

Klickitat Valley Health
Phone: 509-772-2695 Fax: 509-773-3354

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 CockroftGault 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 calcium and vitamin D supplements as prescribed by provider

☒ 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.

Patient Name:
DOB:

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Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent 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:

**Required for all external orders*

Provider Signature: _____ **Date _____**

Printed name: _____

Patient Name:
DOB: