Oregon Health & Science University Hospital and Clinics Provider's Orders PO9031 ADULT AMBULATORY INFUSION ORDER **Ibandronate (BONIVA) Injection** Page 1 of 2	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Confirm patient has had recent oral/dental evaluation prior to initiating therapy.
3. All patients should be prescribed daily calcium and Vitamin D supplementation.
4. Discuss risk versus benefit regarding osteonecrosis of the jaw and hip fracture prior to treatment.
5. A complete metabolic panel must be obtained within 28 days prior to starting treatment.
6. **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.

LABS:

- ☐ CMP, routine, ONCE, every visit

NURSING ORDERS:

1. TREATMENT PARAMETER – Pharmacist to calculate corrected calcium. Hold and contact provider for corrected calcium less than 8.4 or CrCl less than 30 mL/min.
2. Review previous creatinine clearance and previous serum calcium and albumin. If no results in past 28 days, order CMP.
3. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.
4. Remind patient to take at least 500 mg elemental calcium twice daily and 400 IU Vitamin D daily.

MEDICATIONS:

ibandronate (BONIVA) 3 mg, intravenous bolus, over 15 to 30 seconds, every 12 weeks for 4 treatments

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); 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/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610