

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



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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:** _____

Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

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

☐ **Beaverton**

OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006

Phone number: 971-262-9000

Fax number: 503-346-8058

☐ **NW Portland**

Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210

Phone number: 971-262-9600

Fax number: 503-346-8058

☐ **Gresham**

Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030

Phone number: 971-262-9500

Fax number: 503-346-8058

☐ **Tualatin**

Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062

Phone number: 971-262-9700

Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders