MPP INFUSION CENTERS
www.mppinfusion.com

Fax Referrals To: (855) 891-2191
Email Referrals To: MPPReferral@mppinfusion.com
Have a Question? (855) 478-1528

IBANDRONATE SODIUM ORDER FORM

(* - Required Fields)

____ STAT REQUEST
(*REASON MUST BE PROVIDED BELOW)

_____ New Referral _____ Order Renewal _____ Medication/Order Change
_____ Benefits Verification Only _____ Discontinuation Order

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: M F
ADDRESS:		PHONE:	
WEIGHT: LBS KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

IBANDRONATE SODIUM ORDER*:

ICD-10*: ______________________________

*(SELECT **ONE** OF THE FOLLOWING)*

____ Dosing: 3mg IV every 3 months

Patient is currently taking Calcium/Vitamin D Supplement _____YES ____NO

Physician Signature* ________________________________

Date*(Order is Valid for One Year) ____________________
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

_____ Osteoporosis

_____ Other___________________________

***STAT REASON:**
(STAT request will be assessed per MPP policy and procedure)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

_____ DEXA Results (w/in 2 years)

_____ Serum Calcium (w/in 12 months)

_____ Creatinine (w/in 12 months)

Last Infusion/Injection Date: ____________________

STANDING LAB ORDERS: _____ CMP _____ CBC

____ Labs to be drawn by Infusion Center Frequency ________________________________

NOTES/ADDITIONAL COMMENTS:

Locations:

--------Colorado--------
___ Lakewood

---------Florida---------
___ Jacksonville
___ Kissimmee
___ Port St. Lucie
___ Suncoast
___ Winter Park

------Oklahoma--------
___ Tulsa

----------Texas----------
___ Arlington
___ Cedar Hill
___ Dallas
___ Denton
___ Ft. Worth
___ Irving
___ Rockwall
___ Southlake
___ Flower Mound
___ Plano
___ Tyler

REVISION DATE- 09/2021