



IBANDRONATE SODIUM (BONIVA) REFERRAL

(* - Required Fields)

STAT REQUEST

(*REASON MUST BE PROVIDED BELOW)

New Referral
 Referral 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(BONIVA) Infusion *: **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) _____

* NPI # _____ *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 (to be drawn by the clinic): CMP CBC *Frequency _____

FOR MPP USE ONLY

Referral Reviewed and Accepted by: _____ Date approved: _____

Additional information needed/ notes: _____

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- 01/2022