Fax Referrals To: (855) 891-2191
Email Referrals To: referrals@vivoinfusion.comHave a Question? (855) 478-1528

BONIVA™ (ibandronate sodium) REFERRAL
(- Required Fields)*

STAT REQUEST
(*REASON MUST BE PROVIDED BELOW)

New Referral **Referral Renewal** **Medication/Treatment 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)*:

BONIVA Infusion*:
*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: ______________________
(required & specific as possible)

Dose: 3 mg IV every 3 months

Patient is currently taking Calcium/Vitamin D Supplement Yes No

Physician Signature* ______________________ **Date*(Referral Valid for One Year)**______________________
***NPI #**______________________
Infusion will be administered per VIVO policy and protocols

ICD-10 Description:

***STAT REASON:**
(STAT requests will be assessed per VIVO policy and protocols)

Last Infusion/Injection Date: ______________________

REQUIRED DOCUMENTATION CHECKLIST:

Patient Demographics

Insurance Card/Information

Clinical/Progress Notes

DEXA Results within 2 years

Serum Calcium within 12 months

Creatinine within 12 months

STANDING LAB REQUEST (to be drawn by clinic): CMP CBC *Frequency ______________________

Additional comments/notes:

Locations:

--------Colorado-------

___ Lakewood

--------Florida---------

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

---------Ohio---------

Beachwood
Middleburg Hts.
Painesville
Youngstown
Westlake
Fairlawn

-------Oklahoma-------

Tulsa

---------Texas---------

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

REVISION DATE- 5/2022