



Fax Referrals To: (855) 891-2191  
 Email Referrals To: [referrals@vivoinfusion.com](mailto:referrals@vivoinfusion.com) Have  
 a Question? (855) 478-1528

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

**STAT REQUEST**  
 (\*REASON MUST BE PROVIDED BELOW)

<b>New Referral</b>	<b>Referral Renewal</b>	<b>Medication/Treatment Change</b>
<b>Benefits Verification Only</b>		<b>Discontinuation Order</b>

**PATIENT INFORMATION**

NAME*:		DOB*:	SEX: <input type="checkbox"/> M <input type="checkbox"/> 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*

<b>ICD-10 Description:</b>	<b>REQUIRED DOCUMENTATION CHECKLIST:</b>
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<p>*STAT REASON:          (STAT requests will be assessed per VIVO policy and protocols)</p> <p>Last Infusion/Injection Date: _____</p>	<p>Patient Demographics</p> <p>Insurance Card/Information</p> <p>Clinical/Progress Notes</p> <p>DEXA Results within 2 years</p> <p>Serum Calcium within 12 months</p> <p>Creatinine within 12 months</p>
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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
- Dayton
- Canton

-----Oklahoma-----

Tulsa

-----Texas-----

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