Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

BONIVA IVp

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ Dexa Scan (-2.5 T score or more severe)
***if no -2.5 T score, please send history of fracture documentation*
☐ Documentation to support primary diagnosis
(Clinical/progress notes, other medications tried & failed, labs, diagnostic tests, etc.)
☐ **Required Labs:** CMP/BMP within 60 days, Vit D within a year

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis ICD-10: ☐ Senile Osteoporosis (ICD-10:_____) ☐ Paget' s disease of bone (ICD-10:_____)
☐ Glucocorticoid-induced osteoporosis (ICD-10:_____) ☐ Other (ICD-10:_____)

J Code: J1740

BONIVA IVp ORDERS

Patient Wt._____kg

*Patient is currently taking calcium/vitamin D supplementation ☐ YES ☐ NO

☐ Boniva 3mg IVp every 3 months

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	