THE UNIVERSITY OF KANSAS HOSPITAL 3901 Rainbow Boulevard Kansas City, Kansas 66160 PHYSICIAN'S ORDER FORM	Do not write in this box DT0017	PATIENT LABEL

DATE & TIME	#	ORDERS IBANDRONATE SODIUM (BONIVA®) (For outpatient use only)
		Reference: www.boniva.com accessed 3/25/2009.
	1.	Attending Physician:_____ Pager:_____ Resident Physician:_____ Pager:_____
	2.	**Order initiation date**: *(Expires 6 months from initiation date)*
	3.	**Diagnosis:** **ICD-9 Code:** ☐ **733.01 (post menopausal osteoporosis)** ☐ **733.09 (other osteoporosis)** ☐ **Other:**_____ **(ICD-9**_____**)**
	4.	**Allergies:** **Patient weight:** _____**kg**
	5.	**Labs** to be drawn prior to infusion:
	6.	**Nursing:** • Confirm previous ibandronate sodium (Boniva®) infusion was completed greater than 3 months ago. • Obtain patient's VS prior to the infusion • Confirm eGFR is ≥ 30 mL/min • Confirm serum calcium is 9-11 mg/dL • If unable to confirm, hold infusion and notify physician
	7.	**Medications:** • Intravenous ibandronate sodium (Boniva®) 3mg IV push over 15-30 seconds.
	8.	Discharge to home.

Physician Signature: _____ Pager: _____ Date:_____ Time:_____

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