Weight: __________ kg  Height: __________ cm

Allergies: _____________________________________________

Diagnosis Code: ________________________________________

Treatment Start Date: __________  Patient to follow up with provider on date: ____________

**This plan will expire after 365 days at which time a new order will need to be placed**

GUIDELINES FOR ORDERING
1. Send FACE SHEET and H&P or most recent chart note.
2. Confirm patient has had recent oral/dental evaluation prior to initiating therapy.
3. All patients should be prescribed daily calcium and Vitamin D supplementation.
4. Discuss risk versus benefit regarding osteonecrosis of the jaw and hip fracture prior to treatment.
5. A complete metabolic panel must be obtained within 28 days prior to starting treatment.

LABS:
☐ CMP, routine, ONCE, every visit

NURSING ORDERS:
1. TREATMENT PARAMETER – Pharmacist to calculate corrected calcium. Hold and contact provider for corrected calcium less than 8.4 or CrCl less than 30 mL/min.
2. Review previous creatinine clearance and previous serum calcium and albumin. If no results in past 28 days, order CMP.
3. Assess for new or unusual thigh, hip, groin, or jaw pain. Inform provider if positive findings or if patient is anticipating invasive dental work.
4. Remind patient to take at least 500 mg elemental calcium twice daily and 400 IU Vitamin D daily.

MEDICATIONS:

ibandronate (BONIVA) 3 mg, intravenous bolus, over 15 to 30 seconds, every 12 weeks for 4 treatments
By signing below, I represent the following:
I am responsible for the care of the patient (who is identified at the top of this form);
I hold an active, unrestricted license to practice medicine in: □ Oregon □ __________________ (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);
My physician license Number is # __________________ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: ___________________________ Date/Time: ___________________________
Printed Name: ___________________________ Phone: ___________________________ Fax: ___________________________

OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient’s preferred clinic location:

☐ Beaverton
  OHSU Knight Cancer Institute
  15700 SW Greystone Court
  Beaverton, OR 97006
  Phone number: 971-262-9000
  Fax number: 503-346-8058

☐ NW Portland
  Legacy Good Samaritan campus
  Medical Office Building 3, Suite 150
  1130 NW 22nd Ave.
  Portland, OR 97210
  Phone number: 971-262-9600
  Fax number: 503-346-8058

☐ Gresham
  Legacy Mount Hood campus
  Medical Office Building 3, Suite 140
  24988 SE Stark
  Gresham, OR 97030
  Phone number: 971-262-9500
  Fax number: 503-346-8058

☐ Tualatin
  Legacy Meridian Park campus
  Medical Office Building 2, Suite 140
  19260 SW 65th Ave.
  Tualatin, OR 97062
  Phone number: 971-262-9700
  Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders