alera care
advanced infusion centers™

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Ibandronate

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Last infusion date (if applicable): ____________________

Is the patient pregnant, planning a pregnancy or nursing: Yes No Does the patient need interpreter services: Yes No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

M81.0 Age-related osteoporosis without currentpathological fracture

M81.8 Other osteoporosis without current pathological fracture

Other: ______________________________

Medication Order

Ibandronate **Dose:** 3mg IV **Frequency:** Every 3 months

Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs (Calcium, Creatinine)

Insurance Card (front and back) Current Medications History/Progress Notes

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _________________ (If not indicated order will expire one year from date signature) Check here if this is a stat order