

Ibandronate

Provider Order Form rev. 7/20/2022



www.vascoinfusion.com
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PATIENT INFORMATION

Patient Name:		DOB:		
Patient Phone:		Patient Email:		
NKDA	Allergies:	Weight lbs/kg:	Height:	
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change	Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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ICD-10 CODE

M81.0 Age-related osteoporosis without current pathological fracture

M81.8 Other osteoporosis without current pathological fracture

Other: _____

MEDICATION ORDER

Ibandronate

Dose:

3mg IV

Frequency:

Every 3 months

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print)	Provider Signature	Date
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Check here if this is a stat order