



Oregon Medical Group Infusion Center

1007 Harlow Road, Springfield, Oregon 97477

Phone: 541-741-0387 Fax: 541-242-4634

Ibandronate (Boniva) Orders

Name: _____ DOB: _____

Diagnosis/Indication: _____ ICD-10 Code: _____

1. Vital signs: Initial, PRN
2. Peripheral IV site with saline lock, may use existing PICC line or port-a-cath if available.
3. Boniva (Ibandronate Sodium) 3mg IV push over 30 seconds. Administer on day 1 and then every 3 months for 12 months.
4. Pre-medications to be given 30 minutes prior to infusion (optional)

OMG Infusion Center Pre-Medication Protocol

OR

Administer the following routine pre-medications prior to each infusion

Acetaminophen (Tylenol) 650 mg PO

Antihistamine (Select one)

Diphenhydramine (Benadryl) 25 mg PO

Diphenhydramine (Benadryl) 25 mg IV infusion over < 10 mins

Loratadine (Claritin) 10 mg PO

Methylprednisolone (Solu-Medrol) 40 mg IV infusion over < 10 min, not to exceed 50 mg/min

Methylprednisolone (Solu-Medrol) 100mg IV infusion over < 10 min, not to exceed 50mg/min

Ondansetron 4 mg IV **OR** Ondansetron 8 mg IV

Other: _____

5. For infusion reaction (**Must select one to be considered a complete order**)

Acute Infusion Reaction Protocol

Other _____

Provider Signature: _____ Date: _____
(NO PROVIDER STAMPS) (Orders expire after 365 days)

Provider's Printed Name: _____ Time: _____