



**Phone: 1-888-899-7447**  
**Fax: 1-866-368-9808**

**CAP**  
**Osteoporosis**  
**Patient Order Form**

**PATIENT INFORMATION**

Patient Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Allergies <input type="checkbox"/> NKDA	
Date of Birth		SSN#	Weight _____ in <b>kg</b> ONLY Date	
Address		City	State	Zip
Phone # (Home)	(Work)	Email address (optional)		

**INSURANCE INFORMATION (PLEASE ATTACH A PHOTOCOPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS)**

Primary Insurance		Medicare ID
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #

**DIAGNOSIS**

733.0 Treatment of osteoporosis
  731.0 Paget's Disease of Bone
  Other: \_\_\_\_\_

**PRESCRIPTION INFORMATION**

Medication	Dose	Directions/Frequency of Administration	Total # Doses
<input type="checkbox"/> Boniva® (ibandronate) injection	3 mg/3 ml	<input type="checkbox"/> Give 3mg IV over 15-30 seconds <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Reclast® (zoledronic acid) injection	5 mg/100 ml	<input type="checkbox"/> Give 5mg IV over no less than 15 minutes <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Other:			
<input type="checkbox"/> Other:			

**DELIVERY INSTRUCTIONS**

<b>Order will be shipped to the address provided below.</b> <b>Physician must be registered with CAP at this location and this must be the site of administration.</b>	<b>Administration Date *</b> (date of infusion/injection)
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**PHYSICIAN CONTACT INFORMATION & AUTHORIZATION**

Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address		City/State/Zip
DEA #	UPIN #	
CAP PIN #	NPI #	

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (required to process prescription – stamped signatures are not permissible)

**\*If this order is needed in less than 48 hours please call 888-899-7447 to place order.**