Osteoporosis Referral Form

Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice

1. Patient Information

Patient Name: ___________________________ Birthdate: ___________ Sex: ☐Male ☐Female Weight______________ ☐lbs. ☐kg
Preferred Phone: ____ Known Allergies____
Address: ____ City: ____________________ State______________ Zip: ______________

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2. Prescriber Information

Prescriber Name: ____ NPI#__________________________ Tax ID#_______________________
Address: ____ Phone: ________________________ Fax: __________________________
City, State, Zip: ____ Key Contact: ____

3. Diagnosis/Clinical Information

New therapy for patient: ☐ Yes ☐ No High risk patient: ☐ Yes ☐ No

Diagnosis:

- ☐ M80.0 Age-related osteoporosis with fracture
- ☐ M81.0 Age-related osteoporosis w/o fracture
- ☐ M81.8 Other osteoporosis without fracture
- ☐ M88.0 - M88.9 Paget's Disease
- ☐ M94.9 Disorder of cartilage, unspecified
- ☐ M80.8 Other osteoporosis with fracture
- ☐ M81.6 Localized osteoporosis
- ☐ M85.9 Bone density and structure disorders
- ☐ M89.9 Disorder of bone, unspecified
- ☐ Other: ___________________________________

BMD/T-score: ____________ | Date: ______________ | Location: ________________________________

Osteoporotic fracture - Date(s): _____________ Locations: ____________________________ ☐ None

FRAX Score: _________________Hip _________________Major Osteoporotic Fracture Probabilities

Risk Factors :____
____

Comorbidities:____

Prior Treatment ☐ Yes ☐ No

List therapy, start/end dates: ____________________________
____
____
____
____
____

Other Information: _____________________________________
____
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____

Please FAX recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

4. Prescription Information

Medication	Dose/Strength	Sig	QTY.	Refills
☐ Boniva®	☐ 3 mg/3 mL Prefilled Syringe	☐ Inject the contents of 1 PFS intravenously over 15-30 seconds every 3 months. To be administered by a healthcare professional.	1 box	
☐ Evenity®	☐ 105 mg/1.17 mL Prefilled Syringe	☐ Inject 2 separate injections (105 mg each) for a total dose of 210 mg once monthly (injection should be administered by a health-care provider)	1 box	
☐ Forteo®	☐ 2.4 mL Prefilled Syringe	☐ Inject 20 mcg SC as directed daily	1 box	
☐ Prolia®	☐ 60mg Prefilled Syringe	☐ Inject 60mg SC once every 6 months	1 vial	
☐ Tymlos™	☐ 3120 mcg/1.56 mL Prefilled Pen 30 daily doses of 80 mcg	☐ Inject 80mcg SC as directed, once daily	1 box	
☐ Pen Needles		☐ Use as needed	30 day supply	
☐ Other				

Dispensing Options: ☐Patient ☐ Prescriber's Office

Prescriber Signature: Prescriber, please sign and date below	
Dispense as Written Date	Substitution Permitted Date

I authorize Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.