OSTEOPOROSIS REFERRAL FORM

Updated January 2021

Patient Name ______________________ Today's Date__________ ☐ *NEW* Patient ☐ *CURRENT* Patient
DOB __________ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language __________
Best Phone ______________ Email ________________________
Street Address ______________________ Apt#_____ City ______________ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address ______________________
Allergies ____
Current Medications including OTC's (*please fax a complete list*) ______________________

Please Fax Insurance Card(s) both sides
Insured's Name ______________________
Relation to Patient ______________________
Primary Insurance ______________________
ID# ______________ Group # ______________
Secondary Insurance ______________________
ID# ______________ Group # ______________

Ordering Prescriber ______________________
Office Contact ______________________
Street Address ______________________ Suite #_____
City ______________ State _____ Zip _____
Tel ______________ Fax ______________
Email ______________________
License# ______________________
NPI# ______________________

ICD-10 Code ☐ **M80.0** Age Related Osteoporosis with Fracture ☐ **M80.8** Other Osteoporosis with Fracture
☐ **M81.0** Age Related Osteoporosis without Fracture (Senile/Postmenopausal) ☐ **M81.6** Localized Osteoporosis
☐ **M81.8** Other Osteoporosis without Fracture ☐ **M85.9** Disorder of Bone Density & Structure, Unspecified (Osteopenia)
☐ **M89.9** Disorders of Bone, Unspecified ☐ **M84.48XA** to **M84.40XA** Pathological Fracture, Unspecified Site

Fracture Site(s): ________ Date: ____________ Lowest Dexa T-score: ________ Site: ________ Date: ____________

☐ Yes ☐ No **Does the patient have > 1 risk factor for fracture?** If Yes, please explain: ______________

☐ Yes ☐ No **Is the patient unable to remain in an upright position during post oral bisphosphonate administration?**

☐ Yes ☐ No **Does the patient have documented treatment failure after an adequate trial of at least two oral bisphosphonates?**
If yes, check all that apply: ☐ Fosamax or Fosamax plus D (alendronate) ☐ Didronel (elidronate)
☐ Skelid (tiludronate) ☐ Actonel or Actonel with Calcium or Atelvia (risedronale)
☐ Oral Bonlva (ibandronate) ☐ Other ______________

☐ Yes ☐ No **Does the patient have documented treatment failure after an adequate trial of at least one oral bisphosphonate and one SERM?**
If yes, check all that apply: ☐ Fosamax or Fosamax plus D (alendronate) ☐ Didronel (elidronate)
☐ Skelid (tiludronate) ☐ Actonel or Actonel with Calcium or Atelvia (risedronale)
☐ Oral Bonlva (ibandronate) ☐ Tamoxifen (nolvadex) ☐ Evista (raloxifene) ☐ Femara (letrozole)
☐ Fareston (toremlfene) ☐ Other ______________

☐ Yes ☐ No **Does the patient have a documented medical reason (intolerance, hypersensitivity, and/or contraindication) to avoid using oral bisphosphonates or SERMS?**

☐ Yes ☐ No **Does the patient have Dysphagia (difficulty swallowing)?**

Please check or list all indications that apply to this patient: If any of these are checked, please refer to the product package insert for appropriate indications, warnings, and contraindications.
☐ Presence or history of osteoporotic vertebral compression fracture and/or hip fracture
☐ Currently taking calcium & Vitamin D ☐ BMD greater than -2.5 ☐ BMD -1.0 and -2.5
☐ Other ______________

PRESCRIPTION

☐ **FORTEO 20 mcg Multi-dose Pen**
SIG: Inject 20 mcg subcutaneously once a day
QTY: 1 Pen Refill: _______
PEN NEEDLES ☐ 31 gauge-5mm ☐ 32 gauge-4mm
SIG: Use as directed with Forteo
QTY: 30 Needles Refill: _______

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)______________________ **Date** __________

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should 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.

PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

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