



Specialty Pharmacy With A Personal Touch

Osteoporosis Referral Form

Please fax to
866.279.3315

402 Wilkins Wise Road STE 38
Columbus, MS 39705 p
866.279.3314

Patient Information	Date: _____ Patient SS#: _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
	Patient's First Name: _____	Patient's Last Name: _____	
	Address: _____	City: _____	State: _____ Zip: _____
	Best Phone Number: _____	Alternate Phone Number: _____	
	DOB: _____	Weight: _____	kgs or lbs (circle one) Recorded Date: _____
	Caregiver: _____	Allergies: _____	

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Clinical Information	DIAGNOSIS:	Prior (FAILED) Therapy:																
	<input type="checkbox"/> 733.00 Osteoporosis, Unspecified	<table border="1"> <thead> <tr> <th>Therapy</th> <th>Date(s)</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Fosamax</td><td></td></tr> <tr><td><input type="checkbox"/> Actonel</td><td></td></tr> <tr><td><input type="checkbox"/> Forteo</td><td></td></tr> <tr><td><input type="checkbox"/> Prolia</td><td></td></tr> <tr><td><input type="checkbox"/> Reclast</td><td></td></tr> <tr><td><input type="checkbox"/> Boniva</td><td></td></tr> <tr><td><input type="checkbox"/> Other (please list): _____</td><td></td></tr> </tbody> </table>	Therapy	Date(s)	<input type="checkbox"/> Fosamax		<input type="checkbox"/> Actonel		<input type="checkbox"/> Forteo		<input type="checkbox"/> Prolia		<input type="checkbox"/> Reclast		<input type="checkbox"/> Boniva		<input type="checkbox"/> Other (please list): _____	
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<input type="checkbox"/> 733.01 Senile Osteoporosis																		
<input type="checkbox"/> 733.02 Idiopathic Osteoporosis																		
<input type="checkbox"/> 733.03 Disuse Osteoporosis																		
<input type="checkbox"/> 733.09 Other Osteoporosis																		
<input type="checkbox"/> V58.65 Long-term (current) use of Steroids																		
<input type="checkbox"/> Other: _____																		
Date of Diagnosis: _____ BMD/T-Score: _____	Is patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
History of osteoporotic fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
If no, is patient at high risk? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
If yes, date of fracture: _____	Location of fracture: _____																	

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
<input type="checkbox"/> Forteo®	<input type="checkbox"/> 600 mcg/2.4 mL Pen	<input type="checkbox"/> Inject 1 dose (20 mcg) subcutaneously once daily. Discard device 28 days after first use.	<input type="checkbox"/> 1 pen (4-week supply) <input type="checkbox"/> 3 pens (12-week supply)	_____
<input type="checkbox"/> BD® Mini Pen Needles	<input type="checkbox"/> 31G x 3/16"	<input type="checkbox"/> Use with Forteo® pen once daily as directed	<input type="checkbox"/> #90 Pen Needles <input type="checkbox"/> #30 Pen Needles	_____
<input type="checkbox"/> Prolia®	<input type="checkbox"/> 60 mg/1 mL PFS	<input type="checkbox"/> Inject the contents of 1 syringe (60 mg) subcutaneously every 6 months	1 Prefilled Syringe	_____
<input type="checkbox"/> Tymlos®	<input type="checkbox"/> 80 mcg/Pen	<input type="checkbox"/> Inject 80 mcg subcutaneously into abdomen once daily	1 Pen	_____
<input type="checkbox"/> Pen Needles	<input type="checkbox"/> 8 mm 31G	<input type="checkbox"/> Use with Tymlos® pen once daily as directed	<input type="checkbox"/> #90 Pen Needles <input type="checkbox"/> #30 Pen Needles	_____

Forteo® Injection Training	<input type="checkbox"/> Patient has received pen and injection training
	<input type="checkbox"/> Physician's office to provide injection training
	<input type="checkbox"/> Pharmacy to coordinate injection training

Prescriber Information	Date Shipment Needed: _____ Ship to: _____ Patient _____ Physician/Clinic
	Ship to Other: _____
	Physician's Name (please print): _____ Contact Name: _____
	Phone #: _____ Fax #: _____ NPI #: _____
	Office Address: _____ City: _____ State: _____ Zip: _____
	I authorize EntrustRx Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. Physician's Signature: _____ Date: _____

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.