



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 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, 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:

Does the patient have > 1 risk factor for fracture? If Yes, please explain:
Is the patient unable to remain in an upright position during post oral bisphosphonate administration?
Does the patient have documented treatment failure after an adequate trial of at least two oral bisphosphonates?
Does the patient have documented treatment failure after an adequate trial of at least one oral bisphosphonate and one SERM?
Does the patient have a documented medical reason (intolerance, hypersensitivity, and/or contraindication) to avoid using oral bisphosphonates or SERMS?
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.