Osteoporosis Referral Form

Referral for Medication and Patient Management Program

Phone: 877 385 0535 Fax: 877 326 2856

OptiMed SPECIALTY PHARMACY

V.07.20.17.A

Patient Demographics

Name: _____ ☐M ☐F

DOB: _____ SS#: _____

Phone: _____ 2nd Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary language, if other than English: _____

****Please fax a copy (front and back) of the patient's insurance card as well as any relevant clinical notes/documents****

Provider Information

Prescriber: _____

_____

Phone: _____ Fax: _____

Address: _____

_____

NPI: _____ Office contact: _____

This is a: ☐New Rx ☐Refill

Training by: ☐Prescriber's office ☐Pharmacy to facilitate ☐Not needed

Deliver first fill to: ☐Prescriber's office ☐Patient ☐Other: _____

Clinical Information

Diagnosis (Include ICD-10 Code): _____

Patient weight: _____ **Height:** _____

Allergies: _____

Serum Calcium Level: _____ **Date:** _____

DEXA Scan Results (T-score): _____

Fracture History: _____

_____

_____

List prior failed therapies, including duration and reason for discontinuation:

Drug/Dose	Duration	Reason for discontinuation

☐Patient has not tried or failed any prior therapy.

Prescription Information

Medication	Directions	Quantity	Refills
☐Forteo® multi-dose pen (teriparatide)	Inject 20mcg subcutaneously once daily. ☐Check here to enroll the patient into Forteo® Connect ongoing support.	1 pen (28-day supply)	_____
☐Pen needles	Use a new pen needle daily for Forteo® injection.	1 box (#100)	_____
☐Prolia® 60mg syringe (denosumab)	Inject 60mg subcutaneously every 6 months. ****Must be administered by a healthcare professional.**** ☐OptiMed Specialty Pharmacy to administer Prolia. (Only available for patients residing in Southwest Michigan)	1 syringe (180-day supply)	_____
☐Tymlos® multi-dose pen (abaloparatide)	Inject 80mcg subcutaneously once daily.	1 pen (30-day supply)	_____
☐Pen needles	Use a new pen needle daily for Tymlos® injection.	1 box (#100)	_____
☐Other Medication Drug: Dose:	Directions:	Quantity:	Refills:

Provider Signature: _____ **Date:** _____

My signature for this prescription also authorizes OptiMed Pharmacy and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process.

Additional Information/Notes for the Pharmacy: