

Osteoporosis Referral Form

Referral for Medication and Patient Management Program

Phone: 877 385 0535 Fax: 877 326 2856



Patient Demographics	Provider Information
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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****

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

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

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. Confidentiality statement: This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error please notify the sender noted above and destroy all transmitted material.

Additional Information/Notes for the Pharmacy: