

OSTEOPOROSIS REFERRAL FORM

PATIENT INFORMATION (please attach insurance card)

Name:		<input type="checkbox"/> M <input type="checkbox"/> F	DoB:	
Street:		City:		State: Zip:
Phone:	Phone:	Allergies:		

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- ☐ **M81.0** osteoporosis without pathological fracture
☐ **M80.08XA** osteoporosis with current pathological fracture
☐ Other: _____

- Is the patient taking calcium and vitamin D? ☐ yes ☐ no
- Has the patient tried and failed an oral bisphosphonate? ☐ yes ☐ no
- Does the patient have a contraindication AND/OR intolerance to oral bisphosphonate therapy? ☐ yes ☐ no
- Does the patient have a history of osteoporotic fracture? ☐ yes ☐ no

Labs & Procedures (please attach most recent results):

- ☐ CMP ☐ date of most recent DEXA: _____
☐ T score: _____ ☐ Z score: _____

Site: _____ Date: _____
 Site: _____ Date: _____
 Site: _____ Date: _____

Current medication(s) with date(s) started: _____
 Prior medication(s) with date(s) of use: _____

PRESCRIPTION

☐ **DAW** (deliver to ☐ patient ☐ office)

Medication	Route	Dose/Strength	Directions/Sig	Quantity	Refills
<input type="checkbox"/> Check this box to authorize the pharmacy to interchange to the plan's preferred biosimilar if needed					
<input type="checkbox"/> ibandronate (Boniva)	IV	3mg/3mL PFS	infuse 3mg IV as a 15-30 second bolus every 3 months	3mL	
<input type="checkbox"/> Prolia	sub-Q	60mg/mL PFS	inject 60mg sub-Q every 6 months	1	
<input type="checkbox"/> teriparatide (Forteo)	sub-Q	pen: <input type="checkbox"/> 600mcg/2.4mL <input type="checkbox"/> 620mcg/2.48mL	inject 20mcg sub-Q once daily		
<input type="checkbox"/> zoledronic acid (Reclast)	IV	5mg/100mL soln	Infuse 5mg IV over at least 15 min <input type="checkbox"/> as a 1-time dose <input type="checkbox"/> every 12 months <input type="checkbox"/> every 24 months		
Other:					

PRESCRIBER INFORMATION

Prescriber:		Supervising Physician:	
Contact Name:	Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email:		
Phone:	Ext:	Fax:	
Street:	City:	State:	Zip:
Signature:	Date:	NPI:	