OSTEOPOROSIS REFERRAL FORM

Single Point of Contact: 724-515-7053 Pharmacy 866-213-9821
FAX: 877-526-8823

Start Date

Ship To: ☐ Patient ☐ Office ☐ **Other**

1. Patient Information: Please fax front and back copy of the insurance card (Prescription and Medical)

Patient: _____ Male / Female DOB: _____ Soc. Sec. #_____
First Name Last Name

Address: _____
Street City State Zip

Primary phone number: _____ Alternate phone number: _____

Caregiver: _____ Allergies: _____

Comorbidities: _____ Height: _____ Weight: _____

2. Clinical Information: Please fax recent clinical notes, Labs, Tests, with prescription to expedite the prior authorization

Diagnosis/ICD-10:
- ☐ 733.00 Osteoporosis, unspecified
- ☐ 733.01 Senile osteoporosis
- ☐ 733.02 Idiopathic osteoporosis
- ☐ 733.03 Disuse osteoporosis
- ☐ 733.09 Other osteoporosis
- ☐ V58.65 Long-term (current) use of steroids
- ☐ Other: _____

BMD/T-Score_____
Date: _____
Is patient new to therapy? ☐ Yes ☐ No
History of osteoporotic fracture? ☐ Yes ☐ No
If yes, date of fracture: _____
Location of fracture: _____
If no, is patient at high risk? ☐ Yes ☐ No

Prior Failed Therapies:
- ☐ Actonel ® date (s): _____
- ☐ Boniva ® date (s): _____
- ☐ Forteo® date (s): _____
- ☐ Fosamax ® date (s): _____
- ☐ Prolia® date (s): _____
- ☐ Reclast ® date (s): _____
- ☐ Other _____ date (s): _____

3. Prescription Information: If you need a medication not listed please contact us

Medication	Strength	Directions	Quantity	Refills
☐ **Boniva®**	☐ **3mg/3mL Prefilled Syringe**	**Inject the contents of 1 syringe (3mg) intravenously every 3 months. To be administered by a healthcare professional.**	**1 Prefilled Syringe**	
☐ **Forteo®**	☐ **600 mcg/2.4 mL pen**	**Inject one dose (20 mcg) subcutaneously once daily. Discard device 28 days after first use. Dispensed with Mini Pen Needles: (30 needles per 1 pen dispensed)**	**1 Pen (4 weeks)**	
☐ **Prolia®**	☐ **60 mg / 1 mL Prefilled Syringe**	**Inject the contents of 1 syringe (60 mg) subcutaneously every 6 months.**	**1 Prefilled Syringe**	
☐ **Reclast®**	☐ **5mg / 100 mL vial**	**Infuse 5 mg intravenously over no less than 15 minutes once annually.**	**1 Vial**	

4. Prescriber and Shipping Information

Prescriber (print):_____ Office Contact: _____

Preferred method of contact: ☐ **phone** ☐ **fax** ☐ **email** **preferred contact persons email:**_____

Office Address: _____

Phone: _____ **fax:**_____ **NPI:**_____ **DEA:**_____

Prescriber's Signature:_____ **Date:**_____

I authorizeAccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process**. (NO STAMPS)**

5. Patient Support Programs (optional): Please sign below to enroll in the pharmaceutical company assisted patient support program

Patient Signature:_____ **Date:**_____

6. Insurance Information: Please fax a copy of the insurance card (front & back)