OSTEOPOROSIS
Prescription Referral Form

blue sky SPECIALTY PHARMACY

Phone: 843-352-7662 | Fax: 833-898-3992 | Backup Fax 843-352-7632 | 1501 Belle Isle Ave #150 Mt Pleasant SC 29464

PATIENT INFORMATION - PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS

First Name: _____ Last Name: _____ Date of Birth: _____ ☐M ☐F

Street Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ SSN: _____ Patient Preferred Language: ☐English ☐Spanish ☐ _____

PRESCRIBER INFORMATION

Name: _____ DEA: _____ NPI: _____

Address: _____

Phone Number: _____ Fax Number: _____ Contact Person: _____

Office's Preferred Method of Contact: ☐Phone ☐Fax ☐Portal ☐Email: _____ ☐Other: _____

PATIENT CLINICAL INFORMATION / HISTORY -PLEASE FORWARD ALL CHART NOTES AND LABWORK

Diagnosis: _____ ICD 10: _____ Weight: _____ Height: _____ T-Score: _____

Drug Allergies: _____ Date of Last DEXA: _____

Previous / Failed Medications: _____

History of Fracture: ☐Yes ☐No Date of Fracture: _____ (PLEASE FORWARD DEXA SCAN)

PRESCRIBING INFORMATION

☐ NEW ☐ RESTART ☐ CONTINUING | SHIPPING PREFERENCE: ☐ Deliver Medication to Patient ☐ Deliver Medication to MDO

MEDICATION	DOSAGE	SIG	QTY	RFLS
☐ EVENITY	☐ 150mg/1.17mL PFS	☐ Inject 210mg SC once monthly		
☐ FORETO	☐ 600mcg/2.4mL Pen	☐ Inject 20mcg SC once daily		
☐ 31G Needles	☐ 5mm Pen Needles	☐ Use as directed with Forteo		
☐ PROLIA	☐ 60mg/mL PFS	☐ Inject 60mg SC every 6 months		
☐ TERIPARATIDE	☐ 620mcg/2.48mL Pen	☐ Inject 20mcg SC once daily		
☐ 31G Needles	☐ 5mm Pen Needles	☐ Use as directed with Teriparatide		

PRESCRIPTION SIGNATURE

Dispense as Written: _____ Substitution Permitted: _____ Date: _____

I authorize Blue Sky Specialty Pharmacy and it's representatives to act as my agent in order to initiate and execute the insurance prior authorization process / appeals if necessary, in doing so, to release clinical information via phone / fax to appropriate third party payer