

OSTEOPOROSIS Prescription Referral Form



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
<input type="checkbox"/> EVENITY	<input type="checkbox"/> 150mg/1.17mL PFS	<input type="checkbox"/> Inject 210mg SC once monthly		
<input type="checkbox"/> FORETO	<input type="checkbox"/> 600mcg/2.4mL Pen	<input type="checkbox"/> Inject 20mcg SC once daily		
<input type="checkbox"/> 31G Needles	<input type="checkbox"/> 5mm Pen Needles	<input type="checkbox"/> Use as directed with Forteo		
<input type="checkbox"/> PROLIA	<input type="checkbox"/> 60mg/mL PFS	<input type="checkbox"/> Inject 60mg SC every 6 months		
<input type="checkbox"/> TERIPARATIDE	<input type="checkbox"/> 620mcg/2.48mL Pen	<input type="checkbox"/> Inject 20mcg SC once daily		
<input type="checkbox"/> 31G Needles	<input type="checkbox"/> 5mm Pen Needles	<input type="checkbox"/> 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

Important Notice: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you have received this communication and you are not the intended recipient, you should not disseminate, distribute, or copy this fax. Please notify sender immediately if you have received in error and then destroy this document immediately.