

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

First Name: _____ Last Name: _____ Date of Birth: _____ M F
 Street Address: _____ City: _____ State: _____ Zip: _____
 Cell Phone: _____ SSN: _____ (PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS)

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____
 Address: _____
 Phone Number: _____ Fax Number: _____ Contact Person: _____

PATIENT CLINICAL INFORMATION / HISTORY

Diagnosis: _____ ICD 10: _____ Weight: _____ Height: _____ T-Score: _____
 Drug Allergies: _____ Date of last DEXA: _____
 Previous / Failed Medications: _____
 History of Fracture: Y N Date of Fracture: _____ (PLEASE FORWARD CHART NOTES AND DEXA SCAN)

PRESCRIBING INFORMATION

NEW RESTART CONTINUING | SHIPPING PREFERENCE: Deliver medication to patient Deliver medication to MD

MEDICATION	DOSAGE	SIG	QTY	REFILLS
<input type="checkbox"/> EVENITY	<input type="checkbox"/> 105mg/1.17mL PFS	<input type="checkbox"/> Inject 210mg SC once monthly		
<input type="checkbox"/> FORTEO	<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		
<input type="checkbox"/> TYMLOS	<input type="checkbox"/> 3,120mcg/1.56mL Pen	<input type="checkbox"/> Inject 80mcg SC once daily		
<input type="checkbox"/> 31G Needles	<input type="checkbox"/> 5mm Pen Needles	<input type="checkbox"/> Use as directed with Tymlos		
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		

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 payor.

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