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

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
☐ EVENITY	☐ 105mg/1.17mL PFS	☐ Inject 210mg SC once monthly		
☐ FORTEO	☐ 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		
☐ TYMLOS	☐ 3,120mcg/1.56mL Pen	☐ Inject 80mcg SC once daily		
☐ 31G Needles	☐ 5mm Pen Needles	☐ Use as directed with Tymlos		
☐ _____	☐ _____	☐ _____		
☐ _____	☐ _____	☐ _____		
☐ _____	☐ _____	☐ _____		

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.