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

Prescriber 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 CHART NOTES AND RELEVANT LABS

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 MD

MEDICATION	DOSAGE	SIG	QTY	RFLS
☐ 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		

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.