



866 413-3156 toll free phone
 877 834-1231 toll free fax
 QUESTIONS? Please Contact Us!
 www.REPharmacy.com

Osteoporosis Prescription Referral Form

Send your Rx to: _____ (optional)

Date Medication Needed: _____ Ship To: () Patient's Home () Prescriber's Office () Pick-Up (store location): _____ Injection training by pharmacy?

1) Patient & Insurance Information Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: _____ Birth Date: _____ Sex: () Male () Female Height: _____ Weight: _____ ()lbs. ()kgs.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Insurance Info: _____ Policy Number: _____

2) Prescriber Information

Provider Name: _____ DEA #: _____ NPI #: _____ Tax ID#: _____
 Address: _____ Phone: _____ Fax: _____
 City, State, Zip: _____ Key Contact: _____ Phone: _____

3) Diagnosis/Clinical Information Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

Diagnosis: _____ BMD/T-score: _____ Date: _____
 Other: _____ Does patient have latex allergy? () Yes () No
 Prior failed medications (medication and duration of treatment/reason for d/c): _____ Is Patient at risk for osteoporotic fracture as evident by any of the following?
 _____ History of osteoporotic fracture Site: _____ Date: _____
 Patient has tried and failed an oral bisphosphonate
 Is patient currently on RA therapy? () Yes () No Patient has documented contraindication/is intolerant to oral bisphosphonate therapy (please submit a copy of DEXA w/prescription)
 Medications: _____
 TB/PPD test given? () Yes () No

4) Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
<input type="checkbox"/> Boniva®	<input type="checkbox"/> 3mg/3ml PFS Kit	<input type="checkbox"/> Infuse 3mg IV Push every 3 months <input type="checkbox"/> Other	3 month supply	
<input type="checkbox"/> Forteo®	<input type="checkbox"/> 600mcg/2.4ml PFS	<input type="checkbox"/> Inject 20mcg subcutaneously, as directed, once daily	4 week supply	
<input type="checkbox"/> Pen Needles	<input type="checkbox"/> 31ga 6mm		28 needles	
<input type="checkbox"/> Prolia®	<input type="checkbox"/> 60mg PFS	<input type="checkbox"/> Inject 60mg subcutaneously once every 6 months		
<input type="checkbox"/> Reclast®	<input type="checkbox"/> 5mg/100ml	<input type="checkbox"/> Infuse 5mg IV over 15-20 minutes annually <input type="checkbox"/> Other	1	
<input type="checkbox"/> Tymlos®	<input type="checkbox"/> 3120mcg/1.56ml Pen <input type="checkbox"/> Needle: 31ga	<input type="checkbox"/> Inject 80mcg subcutaneously once daily	1	
<input type="checkbox"/>				

5) Patient Support Programs Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

 Patient Signature _____ Date _____

6) Prescriber Signature Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written _____ Date _____ Substitution Permissible _____ Date _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

#of Prescriptions