Phone: 866-209-5540 **Fax: 800-878-4160**

OSTEOPORISIS REFERRAL FORM

Shipment: Date: _____ Needs By: _____ Ship to: ☐Patient ☐MD Office ☐ Other: _____

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	NPI: _____
City, ST, Zip: _____	Address: _____
Phone: _____	City, ST, Zip: _____
DOB: _____ Gender ☐Male ☐Female	Phone: _____
Last 4 digits of social: _____	Fax: _____
Emergency Contact: _____	Contact Person: _____

CLINICAL INFORMATION

Therapy: ☐ New ☐ Continuation ☐ Reauthorization

☐ **ICD-10**_____ **Description**_____

Disease Description

☐ Postmenopausal osteoporosis with high fracture risk (female)
☐ Postmenopausal osteoporosis prophylaxis
☐ Glucocorticoid-induced osteoporosis treatment/prophylaxis
☐ Hypogonadal osteoporosis with high fracture risk (male)
☐ **Other:** _____

Test Results

☐ Serum Calcium_____
☐ SCr/CrCl _____
☐ BMD_____
☐ T Score_____

Fracture History: _____
_____

Prior Therapies and Duration:

☐ Boniva® _____

☐ Fosamax® _____

☐ Actonel® _____

☐ Reclast ® _____

☐ Other:_____

☐ Other: _____

Latex Allergy: ☐ Yes ☐ No

Allergies:_____

DRUG	STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Tymlos®	☐ 3120mcg/1.56mL Pen	Inject 80mcg subcutaneously once daily		
☐ Pen Needles	☐ 31G - 5mm	Use with Tymlos Pen as directed		
☐ Prolia®	☐ 60mg	Inject 60mg subcutaneously once every 6 months		
☐ Forteo®	☐ 600mcg/2.4mL Pen	Inject 20mcg subcutaneously once daily		
☐ Pen Needles	☐ 31G – 5mm	Use with Forteo Pen as directed		

☐ **Patient has received injection training** ☐ **Physician's office to provide injection training** ☐ **VitalRx to coordinate injection training**

Prescribers Signature: _____ _____ **Date:** _____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

I authorized VitalRx Pharmacy to act on behalf of the prescriber to initiate and complete the prior authorization process including, but not limited to, acquiring any necessary labs, clinic notes and/or imaging.

Revised: 9/28/17