

# OSTEOPOROSIS REFERRAL FORM

Phone: 800-657-2212  
Fax: 310-657-0906

**Please FAX TO: 310-657-0906** **Date Shipment needed** \_\_\_\_\_  
Toll Free Ph: 800-657-2212 Ship To:  Patient  Physician

PATIENT	PHYSICIAN
Patient Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone : (____) _____ - _____ Cell (____) _____ - _____ Work Phone: (____) _____ - _____ Language Spoken: _____ Patient Soc. Sec #: _____ Date of Birth: _____ <p style="text-align: center; font-size: small;">See attached demographic sheet</p>	Physician Name: _____ State Lic. #: _____ DEA# _____ NPI: _____ Tax ID# _____ Address: _____ City: _____ State: _____ ZIP: _____ Physician's Ph: (____) _____ - _____ Physician's Fax: (____) _____ - _____ Nurse/Key Office Contact: _____ Specialty: _____ e-mail: _____

## INSURANCE INFORMATION ( Attach Copies of Cards and fax along this form)

### CLINICAL INFORMATION

Diagnosis: \_\_\_\_\_ ICD-9 Codes: \_\_\_\_\_ Allergies: \_\_\_\_\_

Home Health Nurse Required:  No  Yes

**Please list failed meds relevant to the diagnosis:**  
(bisphosphonates, calcium+D, anabolic agents, etc)

Med	dose	duration	reason to D/C
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate all relevant lab results:  
 lowest Dexa Score: \_\_\_\_\_ Site: \_\_\_\_\_  
 Fracture: yes  no  Site: \_\_\_\_\_  
 Other Clinical Findings: \_\_\_\_\_

TREATMENT	DOSE	DIRECTION	REFILLS
<input type="checkbox"/> Boniva	3mg/3ml inj	3mg ivp q 3 months	_____
<input type="checkbox"/> Forteo	600mcg/ 2.4 ml, 12wks supply x 2yrs	20 mcg sq qd, needle 31G/5mm # 100 PRN	_____
<input type="checkbox"/> Prolia	60mg/ml ___prefilled syr	60mg sq q 6 months	_____
<input type="checkbox"/> Reclast	5 mg/100 ml #1	IV once per year	_____
<input type="checkbox"/> Other (specify): _____			
Comments: _____			
_____			
_____			

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

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