benevere PHARMACY

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TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

# OSTEOPOROSIS REFERRAL FORM

## PATIENT INFORMATION

Patient Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

DOB _____ SSN _____

Drug Allergies _____ ☐ Male ☐ Female

## PRESCRIBER INFORMATION

Prescriber Name _____ DEA# _____

NPI# _____ Tax ID _____

Medicaid ID # _____

Address _____ Suite _____

City _____ State _____ Zip _____

Office Phone _____ Fax _____

Office Contact _____

## INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____

Policy # _____ Group _____

Insurance Phone _____

Secondary Insurance (if applicable) _____

Policy # _____ Group _____

Insurance Phone _____

Prescription Drug Coverage: Company _____ Phone _____

RXGRP# _____ RXBIN# _____ PCN/ID# *(if available)* _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS

## CLINICAL INFORMATION

Prior Failed Medication(s):

_____

_____

_____

Length of Treatment:

_____/_____/_____-_____/_____/_____

_____/_____/_____-_____/_____/_____

_____/_____/_____-_____/_____/_____

Reason for Discontinuing:

_____

_____

_____

Diagnosis Date: _____/_____/_____

☐ M88 Paget's Disease
☐ M81 Unspecified Osteoporosis
☐ M81.0 Postmenopausal/Senile Osteoporosis
☐ M81.8 Drug-induced Osteoporosis
☐ M84.4 Pathological Fracture
☐ Other: _____

Lowest Dexa T-score: _____ Site: _____ Date: _____/_____/_____

Fracture Site(s): _____ Date: _____/_____/_____

Allergies:

| DRUG NAME | PRESCRIPTION ORDERS *(PLEASE CHECK ONE OR MORE)* | QUANTITY | REFILLS |
|---|---|---|---|
| ☐ Boniva® ☐ Pre-filled Syringe | ☐ Inject 3mg IV over 15-30 seconds every 3 months | 3mg/3ml (1 syringe) | |
| ☐ Forteo® ☐ Pen and Supplies | ☐ Inject 20mcg subcutaneously daily | ☐ 1 pen ☐ 3 pens | |
| ☐ Prolia® ☐ Pre-filled Syringe | ☐ Inject 60mg subcutaneously once every 6 months | 60mg/ml (1 syringe) | |
| ☐ Reclast® ☐ Vial | ☐ Infuse 5mg IV, over no less than 15 minutes, every year<br>☐ Infuse 5mg IV, over no less than 15 minutes, every two years | 5mg/100ml (1 vial) | |
| ☐ Tymlos® ☐ Pen and Supplies | ☐ Inject 80mcg subcutaneously daily | ☐ 1 pen ☐ 3 pens | |
| **Injection Training:** ☐ Patient has received injection training ☐ Physician's office to provide injection training | | | |

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

By signing this form and utilizing our services, you are authorizing Benevere and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.
IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not