ameripharma SPECIALTY CARE

OSTEOPOROSIS REFERRAL FORM

Phone: 877-778-0318 Fax: 877-778-0399

Ship to: ☐ Patient ☐ Physician / Clinic Date Shipment Needed: _____ **Rx:** ☐ New ☐ Refill _____

PATIENT INFORMATION

Patient's Full Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Alternate Phone: _____

Patient's Social Security Number: _____

Patient's Date of Birth: _____

Allergies: _____

Patient's Gender (Male or Female): _____

Primary Insurance: _____

ID#: _____ Phone: _____

Secondary Insurance: _____

ID#: _____ Phone: _____

PATIENT MEDICAL HISTORY

iCD-9 Code: _____

Date of Osteoporosis Diagnosis: _____

DEXA T-score (worst sites): _____

Previous Fracture(s): ☐ Yes ☐ No _____

Site of Fracture(s): _____

Others: _____

PRIOR FAILED MEDICATIONS	DURATION
Fosamax (alendronate)	
Actonel (risdronate)	
Miacalcin Nasal Spray	
Evista (raloxifene)	
Boniva	
Reclast	

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

If known, provide T-score BEFORE & AFTER treatment with above listed medication(s)

T-Score at Baseline (with date): _____

T-Score After (with date): _____

Is patient unable to tolerate bisphosphonoates (alendronate or riscronate)? _____

MEDICATION	DOSE / STRENGTH	DIRECTIONS	QTY	REFILLS
Forteo	[ ] 600 mcg / 2.4ml PFS	[ ] Inject 20 mcg SC as directed ONCE a day		
Pen Needles	[ ] 31 gauge [ ] 4mm [ ] 5mm [ ] 6mm			
Prolia	[ ] 60 mg Prefilled Syringe	[ ] Inject 60 mg SC ONCE every 6 months at MD Office		
Reclast	[ ] 5 mg / 100 ml	[ ] Infuse 5 mg IV every 12 months		
Boniva	[ ] 3 mg / 3 ml	[ ] Infuse 3 mg IV every 3 months		

PRESCRIBER INFORMATION

Physician's Name (Please Print): _____ NPI #: _____

Address: _____ License #: _____

City, State, Zip: _____ DEA #: _____

Phone: _____ Fax: _____ Contact Name: _____

Physician's Signature: _____ Date: _____

I authorize AmeriPharma Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.