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: ________
☐ Other: ________
Prior failed medications (medication and duration of treatment/reason for d/c):
☐ ________
Is patient currently on RA therapy? ( ) Yes ( ) No
Medications: ________
TB/PPD test given? ( ) Yes ( ) No

BMD/T-score: ________ Date: ________
Does patient have latex allergy? ( ) Yes ( ) No
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
☐ Patient has documented contraindication/is intolerant to oral bisphosphonate therapy (please submit a copy of DEXA w/prescription)

4) Prescription Information

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

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 Permissable ________ 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 ________

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

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