OSTEOPOROSIS REFERRAL FORM

Mannings® PHARMACY
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Today's Date **Anticipated Start Date**

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

PATIENT INFORMATION:

Patient Name _____ DOB_____ Weight_____ ☐ Male ☐ Female
Street Address_____ Apt#_____ City_____ State_____ Zip_____
Daytime Tel_____ Even Tel_____ Cell_____ Email_____
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed_____

Insured's Name_____ Relation to Patient_____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#_____
Prescription Card Yes No If Yes, Carrier_____ Tel_____ Fax_____ Policy/Group#_____
Bin#_____ Pcn#_____ RX Group#_____ RXID#_____

PRESCRIBING PHYSICIAN INFORMATION:

Prescriber's Name_____ Office Contact_____
Street Address_____ Suite#_____ City_____ State_____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____

CLINICAL INFORMATION:

T-Score:_____ Site: _____ Date: _____ Rehab: ☐ Yes ☐ No Current Medications: _____

Diagnosis Code(s):

- ☐ M80.0: Age Related Osteoporosis with fracture
- ☐ M80.8: Other Osteoporosis with fracture
- ☐ M81.0: Age Related Osteoporosis without fracture
- ☐ M81.6: Localized Osteoporosis
- ☐ M81.8: Other Osteoporosis without fracture
- ☐ M85.9: Disorder of Bone Density and Structure, unspecified (Osteopenia)
- ☐ M88.9: Paget's Disease
- ☐ M89.9: Other and Unspecified disorder of bones and cartilage
- ☐ M84.48XA: Pathological Fracture of Vertebrae
- ☐ M84.459A: Pathological Fracture of Neck of Femur
- ☐ T50.905A: Unspecified adverse effect of other drug, medicinal and biological substance
- ☐ Other:_____

Fracture History:

Site:_____ Date:_____
Site:_____ Date:_____
Site:_____ Date:_____
Site:_____ Date:_____
Site:_____ Date:_____

Comments:

_____
_____
_____
_____
_____

Previously Attempted Medications:

_____ Reason for Discontinuing:_____ Length of Treatment:_____
_____ Reason for Discontinuing:_____ Length of Treatment:_____
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PRESCRIPTION

PLEASE E-SCRIBE & ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **FORTEO® (teriparatide)**	☐ 600mcg/2.4ml Pen	☐ Inject 20 mcg SQ daily		
☐ **Prolia® (denosumab)**	☐ 60mg/ml Syringe	☐ Inject 60mg SQ once every 6 months		
☐ **TYMLOS® (abaloparatide)**	☐ 3.120mg/ml Pen	☐ Inject 80 µg SQ daily		
☐ **RECLAST® (zoledronic)**	☐ 5mg/100ml Vial	☐ Infuse 5mg IV, over no less than 15 minutes, every year ☐ Infuse 5mg IV, over no less than 15 minutes, every two years		
☐ **BONIVA® (ibandronate)**	☐ 3mg/3ml Syringe	☐ Inject 3mg IV over 15-30 seconds every 3 months		

PRESCRIBER SIGNATURE: (signature required. NO STAMPS) **DATE:**