

OSTEOPOROSIS REFERRAL FORM



13 Elizabeth Street New York 10013
 Phone: 212-941-6480
 Toll Free: 888-374-7132
 Fax: 888-910-0186

www.nymannings.com specialty@nymannings.com

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

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:** _____

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 the named addressee, you should 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. PLEASE NOTE: Silver Rod can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.