



Prolia Referral Form

Phone 877.421.3405 Fax 877.421.3406
546 West Las Tunas Drive, San Gabriel, CA 91776

Patient Information

Name (last, first)		Phone <input type="checkbox"/> Home <input type="checkbox"/> Cell	Date of Birth
Home Address, City, State			ZIP
Shipping Address, City, State (if different from above)			ZIP
Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Allergies	

Healthcare Provider Information

Prescriber's First and Last Name		Phone	Fax
Address, City, State			ZIP
Nurse/Key Contact	Physician NPI	DEA	License

Insurance Information (attach copies of card and fax along with this form)

Primary Insurance	Phone	Name (Insured <input type="checkbox"/> Self, <input type="checkbox"/> Spouse, <input type="checkbox"/> Dependent)	ID Number	RXGRP
Secondary Insurance	Phone	Name (Insured <input type="checkbox"/> Self, <input type="checkbox"/> Spouse, <input type="checkbox"/> Dependent)	ID Number	RXGRP
Pharmacy Benefit Card	RXBIN	Member/Subscriber ID Number	RXGRP	PCN

Additional Information

Today's Date	Start Date	Deliver to: <input type="checkbox"/> Home <input type="checkbox"/> Physician	Nurse Training Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Special Instructions
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Diagnosis and Clinical Information

Diagnosis: _____ Please attach any relevant progress notes

ICD-9 Code: _____ Comments:

Lowest DEXA Score _____ Site: _____

History of fracture: ☐ Yes ☐ No Site: _____

Physician Orders

(Please check the following)

PROLIA PFS 60mg/ml Inj #1ml (prefilled syringe) Quantity: _____ Refills: _____ Directions: Inject 60 mg/1ml (1 pre-filled syringe) SC every 6 months	Dose: _____ Length of treatment: _____
Prior Medications: <input type="checkbox"/> Fosamax <input type="checkbox"/> Actonel <input type="checkbox"/> Boniva	Reason for D/C: <input type="checkbox"/> Cannot use Reclast-Cannot find vein <input type="checkbox"/> Low renal clearance cannot infuse <input type="checkbox"/> On Aspirin cannot infuse due to bleeding <input type="checkbox"/> On Coumadin cannot infuse due to bleeding <input type="checkbox"/> Has high serum creatine cannot use Reclast <input type="checkbox"/> Too afraid to self-inject or afraid of IV infusion <input type="checkbox"/> Tried Sample and developed side effects
Dose: _____ Length of treatment: _____	
Reason for D/C: <input type="checkbox"/> GI side effects	
Prior Medications: <input type="checkbox"/> Reclast	

When sending a referral please include all clinical information, including recent lab values, relevant to performing a prior authorization and copies of patient's insurance cards

Physician Signature: _____ **Date** ____/____/____
I authorize MedQuick Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.

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