MEDQUICK PHARMACY

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 ❑ Home ❑ Cell	Date of Birth
Home Address, City, State		ZIP
Shipping Address, City, State (if different from above)		ZIP
Social Security Number	❑ Male ❑ 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 ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Secondary Insurance	Phone	Name (Insured ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Pharmacy Benefit Card	RXBIN	Member/Subscriber ID Number	RXGRP	PCN

Additional Information

Today's Date	Start Date	Deliver to: ❑ Home ❑ Physician	Nurse Training Needed? ❑ Yes ❑ No	Special Instructions

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

Prior Medications: ❑ Fosamax ❑ Actonel ❑ Boniva

Dose:_____ Length of treatment:_____

Reason for D/C: ❑ GI side effects

Prior Medications: ❑ Reclast

Dose:_____ Length of treatment:_____

Reason for D/C:
- ❑ Cannot use Reclast-Cannot find vein
- ❑ Low renal clearance cannot infuse
- ❑ On Aspirin cannot infuse due to bleeding
- ❑ On Coumadin cannot infuse due to bleeding
- ❑ Has high serum creatine cannot use Reclast
- ❑ Too afraid to self-inject or afraid of IV infusion
- ❑ Tried Sample and developed side effects

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.