aleracare
advanced specialty pharmacy

Osteoporosis
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Clinical Information

Primary Diagnosis _____ ***Please include Dx Code # and description Prior Failed*

Meds: _____

Prescription Information

Patient Medical History ICD-10 Code:	Prior Failed Medications: Duration:
Date of Osteoporosis diagnosis:	**Fosamax** (alendronate)
DEXA T-score (worst sites):	**Actonel** (risdronate)
Previous Fracture(s) ◯ Yes ◯ No	**Miacalcin Nasal Spray**
Site of Fracture(s):	**Boniva**
Others:	**Reclast**

Medication	Dose	Directions for Use	Qty	Refills
◯ **FORTEO**	◯ 600mcg/2.4mL Pen	◯ Inject 1 dose (20mcg) subcutaneously once daily. Discard device 28 days after first use.	◯ 1 pen (4 -week supply) ◯ 3 pens(12 week supply)	
◯ **BD MINI PEN NEEDLES**	◯ 31Gx3/16"	◯ Use with Forteo pen once daily as directed	◯ #90 pen needles ◯ #30 pen needles	
◯ **PROLIA**	◯ 60mg/1mL vial	◯ Inject the contents of 1 syringe (60mg) subcutaneously every 6 months	◯ 1 prefilled Syringe	
◯ **RECLAST**	◯ 5mg/100mL vial	◯ Infuse 5mg intravenously over no less than 15 minutes once annually.	◯ One: 5mg/100mL vial	
◯ **BONIVA**	◯ 3mg/3mL PFS	◯ Inject the contents of 1 syringe (3mg) intravenously every 3 months. To be administrated by a healthcare professional	◯ One: 3mg/3mLPFS	

◯ Patient has received pen and injection training ◯ Physician's office to provide injection training

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature _____ **Date** _____