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:	

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Documentation (Required)

◯ Insurance Card (ID & Group #) ◯ Current Medications ◯ History/Progress Notes

Documentation (Required)

◯ CMP ◯ T-score

Diagnosis

ICD-10 Codes: ◯ M81.0 Osteoporosis, age related ◯ Other:_____

Medication	Dose	Directions for Use	Qty	Refills
◯ **EVENITY® PFS** (romosozumab)	◯ 105 mg/1.17 mL x 2	◯ Inject 210 mg subq every month (up to 12 months)		
◯ **FORTEO® Pen** (teriparatide)	◯ 560 mcg/2.24 mL	◯ Inject 20 mcg subq every day		
◯ **PROLIA® PFS** (denosumab) ◯ **Other biosimilar:** _____	◯ 60 mg/mL	◯ Inject 60 mg subq every 6 months		
◯ **RECLAST®** (zoledronic acid)	◯ 5 mg/100 mL IV bag	◯ Infuse 5 mg IV every year		

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**