

Phone: 734-744-4844
 Fax: 734-744-4847

Osteoporosis Referral Form
DATE: _____ **NEEDS BY DATE:** _____ **SHIP TO:** **PATIENT** **OFFICE** **OTHER** _____

PATIENT INFORMATION

 Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Alternate Phone: _____
 Social Security #: _____
 Date of Birth: _____ Sex: M F

PRESCRIBER INFORMATION

 Prescriber Name: _____
 DEA #: _____ NPI#: _____
 Group: _____
 Address: _____
 City, State, Zip: _____
 Phone: (____) _____ Fax: (____) _____
 Contact Person: _____

INSURANCE INFORMATION: (please copy and attach the front and back of insurance and prescription drug card)
CLINICAL INFORMATION - STATEMENT OF MEDICAL NECESSITY
Diagnosis (include ICD-9 code if available) _____

Drug Allergies _____

T-Score _____ **Type** _____ **Date** _____ **Fracture History: Site** _____ **Date** _____ **Site** _____ **Date** _____

Prior Failed Meds	Length of Treatment	Reason for Discontinuing

PRESCRIPTION INFORMATION

Medication	Strength	Dose/Frequency	Quantity	Refills
Forteo	600mg/2.4ml	Inject 20mcg subcutaneously once daily	1 pen	
Prolia	60 mg PFS	Inject 60 mg SC every 6 months	1 syringe	
Reclast	5mg/100ml			

By signing this form and utilizing our services, you are authorizing Pharmacy Specialists and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature _____ **Date** _____

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