Sterling SPECIALTY PHARMACY

Osteoporosis
Prescription Referral Form

NPI: 1225548480 • Ph: 888.618.4126 • F: 866.588.0371

Note: Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

1 Patient Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical).

Patient Name: _____ Birthdate: _____ Sex: ❑ Male ❑ Female Height: _____ Weight: _____ ❑ lbs. ❑ kg.

Allergies: _____ Patient Primary Language: ❑ English ❑ Spanish ❑ Other: _____ ❑ Hearing Impaired

Patient Phone: _____ Patient Email: _____ Caregiver Name: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

2 Diagnosis/Clinical Information

Please FAX Clinical Notes, Labs, & Tests with the prescription to expedite Prior Authorization.

Diagnosis/ICD-10: _____ Diagnosis Date: _____ Other: _____

BMD/T-Score: _____ BMD/T-Score Date: _____

FRAX Score: _____ FRAX Score Date: _____

Is patient new to therapy? ❑ Yes ❑ No

If no, how long has patient been on therapy? (Max use of 2 years) _____

Is patient high risk for fracture? ❑ Yes ❑ No

History of osteoporotic fracture? ❑ Yes ❑ No

If Yes, Location of Fracture: _____ Date of Fracture: _____

Contraindication(s) to bisphosphonate therapy? ❑ Yes ❑ No

If Yes: ❑ Dysphagia ❑ GERD ❑ Ulcer ❑ Other: _____

Please Attach All Medical Documentation, Including:

❑ DEXA Scan ❑ Medication History ❑ CMP Panel ❑ Other Information Pertinent to the Case

Labs: Calcium: _____ Vitamin D: _____ Date: _____

Prior Failed Treatments: Must be completed for all patients.

Treatment Type:	Drug Name:	Dates of Use:
❑ Actonel®		
❑ Boniva®		
❑ Forteo®		
❑ Fosamax®		
❑ Prolia®		
❑ Reclast®		
❑ Other:		

3 Prescription Information

Please be sure to choose both induction and maintenance dose where applicable.

Priority	Medication	Dose/Strength	Direction	Qty.	Refills
#___	❑ EVENITY®	❑ 105mg Prefilled Syringes	❑ Inject 210mg SQ every month for 12 doses in the abdomen, thigh, or upper arm. ❑ Other: _____	❑ 2 ❑ ___	❑ ___
#___	❑ FORTEO®	❑ 600mcg/2.4ml Pen	❑ Inject 20mcg SQ once daily. ❑ Other: _____ ☑ **Pen Needles:** Use as directed with injectable products. (Qty: 1 box) ☑ **Sharps Container:** Use as directed with injectable products. (Qty: 1)	❑ 1 ❑ ___	❑ ___
#___	❑ PROLIA®	❑ 60mg/ml Prefilled Syringe	❑ Inject 60mg SQ every 6 months. ❑ Other: _____	❑ 1 ❑ ___	❑ ___
#___	❑ TERIPARATIDE	❑ 620mcg/2.48ml Prefilled Pen	❑ Inject 20mcg SQ once daily. ❑ Other: _____ ☑ **Pen Needles:** Use as directed with injectable products. (Qty: 1 box) ☑ **Sharps Container:** Use as directed with injectable products. (Qty: 1)	❑ 1 ❑ ___	❑ ___
#___	❑ TYMLOS™	❑ 3,120mcg/1.5ml Prefilled Pen	❑ Inject 80mcg SQ once daily. ❑ Other: _____ ☑ **Pen Needles:** Use as directed with injectable products. (Qty: 1 box) ☑ **Sharps Container:** Use as directed with injectable products. (Qty: 1)	❑ 1 ❑ ___	❑ ___
#___	❑ _____	❑ _____	❑ _____	❑ ___	❑ ___

4 Provider/Prescriber Information

Clinic Name: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____ DEA#: _____ NPI#: _____

Provider Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: Prescriber, please sign and date below (**NO stamps please**):

Signature: _____ Date: _____ Dispense as Written (Write "DAW")

I authorize Sterling Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services, and patient assistance programs.