

Osteoporosis Referral Form



Phone: 808-533-8887
 Fax: 808-533-1888
 E-Prescribing Available

Attention: _____ Need By Date: _____ First Ship To: Patient Physician

Patient	Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Address: _____ City: _____ State: _____ Zip: _____
	Home#: _____ Work #: _____ Cell#: _____ Best time to call: <input type="checkbox"/> AM <input type="checkbox"/> PM
	Soc. Sec #: _____ - _____ - _____ Ethnicity: _____ Primary Language: _____
	Comorbidities: _____ Height: _____ Weight: _____ Date: _____
	Allergies: _____ <input type="checkbox"/> NKDA

Provider	Physician Name: _____ Practice Name: _____ State Lic#: _____ DEA#: _____
	Address: _____ City: _____ State: _____ Zip: _____ NPI#: _____
	Phone#: _____ Fax#: _____ Nurse/Key Office Contact: _____ Ext.: _____

Insurance	Primary Insurance: _____ ID: _____ Phone: _____
	Secondary Insurance: _____ ID: _____ Phone: _____
	* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

Clinical Info	Diagnosis/ICD-10: <input type="checkbox"/> M81.0 Osteoporosis, unspecified <input type="checkbox"/> M81.0 Senile osteoporosis <input type="checkbox"/> M81.8 Idiopathic osteoporosis <input type="checkbox"/> M81.8 Disuse osteoporosis <input type="checkbox"/> M81.8 Other osteoporosis <input type="checkbox"/> Z79.51 Long-term (current) use of inhaled steroids <input type="checkbox"/> Z79.52 Long-term (current) use of systemic steroids <input type="checkbox"/> Other: _____	BMD/T-score: _____ date: _____ Is patient new to therapy? (<input type="checkbox"/> Y / <input type="checkbox"/> N) History of osteoporotic fracture? (<input type="checkbox"/> Y / <input type="checkbox"/> N) If yes, date of fracture: _____ Location of fracture: _____ If no, is patient at high risk? (<input type="checkbox"/> Y / <input type="checkbox"/> N)	Prior failed therapies: <input type="checkbox"/> Actonel® date(s): _____ <input type="checkbox"/> Boniva® date(s): _____ <input type="checkbox"/> Forteo® date(s): _____ <input type="checkbox"/> Fosamax® date(s): _____ <input type="checkbox"/> Prolia® date(s): _____ <input type="checkbox"/> Reclast® date(s): _____ <input type="checkbox"/> Other: _____ date(s): _____
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Prescription

Medication	Strength	Directions	Quantity	Refill
<input type="checkbox"/> Boniva®	3 mg/3 mL PreFilled Syringe	Inject the contents of 1 syringe (3mg) intravenously every 3 months. To be administered by a healthcare professional	1 PreFilled Syringe	
<input type="checkbox"/> Forteo®	600 mcg/2.4 mL pen	Inject 1 dose (20 mcg) subcutaneously once daily. Discard device 28 days after first use. Dispensed with BD Mini™ Pen Needles: (30 needles per 1 pen dispensed)	1 pen (4 weeks)	
<input type="checkbox"/> Prolia®	60 mg/1 mL PreFilled Syringe	Inject the contents of 1 syringe (60 mg) subcutaneously every 6 months	1 PreFilled Syringe	
<input type="checkbox"/> Other				

Injection Training

Patient had received injection training Physician office to provide injection training THP to coordinate injection training

Physicians Signature: _____ Date: _____

I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Confidentiality statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing the information (other than to the intended recipient) or copying the information. If you received this communication in error, please notify the sender immediately by calling 808-533-8887 or by emailing help@thehonolulu-pharmacy.com to obtain instructions as to the proper destruction of the transmitted material. Thank you.