DELMARVA SPECIALTY PHARMACY AT WOODBROOKE

OSTEOPOROSIS REFERRAL FORM

1615 Tree Sap Court Salisbury, MD 21804
Tel 410.677.0561 Fax 410.677.0562

Today's Date

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

May 2018

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

ICD-10 Diagnosis Code Allergies BSA m^2

Patient currently on therapy ☐ Yes ☐ No Date of diagnosis **INSURANCE INFORMATION** Please fax copy of insurance card (front & back)

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

Clinical Information

☐ Yes ☐ No Is the patient unable to remain in an upright position during post oral bisphosphonate administration?

☐ Yes ☐ No Does the patient have documented treatment failure after an adequate trialof at least two oral bisphosphonates?

If yes, please check all that apply: ☐ Fosamax or Fosamax plus D (alendronate) ☐ Didronel (elidronate) ☐ Skelid (tiludronate)
☐ Actonel or Actonel with Calcium or Atelvia (risedronale) ☐ Oral Bonlva (ibandronate) ☐ Other

☐ Yes ☐ No Does the patient have documented treatment failure after an adequate trialof at least one oral bisphosphonate and one SERM?

If yes, please check all that apply: ☐ Fosamax or Fosamax plus D (alendronate) ☐ Didronel (elidronate) ☐ Skelid (tiludronate)
☐ Actonel or Actonel with Calcium or Atelvia (risedronale) ☐ Oral Boniva (ibandronate) ☐ Other
☐ Tamoxifen (nolvadex) ☐ Evista (raloxifene) ☐ Femara (letrozole) ☐ Fareston (toremlfene)

☐ Yes ☐ No Does the patient have a documented medical reason (intolerance, hypersensitivity,and/or contraindication) to avoid using oral bisphosphonates or SERMS?

☐ Yes ☐ No Does the patient have Dysphagia (difficulty swallowing)?

Please check or list all indications that apply to this patient: **If any of these are checked, please refer to the product package insert for appropriate indications, warnings, and contraindications.**

☐ Presence or history of osteoporotic vertebral compression fracture and/or hip fracture
☐ Currently taking calcium and Vitamin D ☐ BMD greater than -2.5 ☐ BMD -1.0 and -2.5 ☐ Other

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **PROLIA**	**60mg/mL Syringe**	SIG: Administer 60 mg every 6 months as a subcutaneous injection	QTY	Refills
☐ **TYMLOS**	**1.56 mL Prefilled Multi Dose Pen**	SIG: Inject 80mcg subcutaneously once a day	QTY	Refills
☐ **FORTEO**	**2.4 mL Prefilled Multi Dose Pen**	SIG: Inject 20mcg subcutaneously once a day	QTY	Refills
☐ **RECLAST**	**5mg/100mL solution**	SIG: Infuse 5mg intravenously over 15 minutes once yearly	QTY	Refills
☐ **BONIVA**	**3mg/mL Syringe**	SIG: Infuse 3mg intravenously over 15 -30 seconds every 3 months	QTY	Refills
☐ **OTHER**		SIG:	QTY	Refills

By signing this form and utilizing our services, you are authorizing Delmarva Specialty and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) **Date**

Please fax completed referral form to **Delmarva Specialty Pharmacy** at **410.677.0562** Visit us at **WWW.DELMARVAPHARMACY.COM** for online fillable forms.