PHARMACY SPECIALIST
Your Partner in HealthCare

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Livonia, MI 48154

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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**