REALO SPECIALTY CARE PHARMACY

OSTEOPOROSIS PRESCRIPTION REFERRAL FORM

Community Consultant Contact:

Fax referral to: 844-814-1944 Phone: 844-814-1943
Email referral form to: connect@realospecialtycare.com
For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: ____ ❑Male ❑Female SS#: ____ DOB: ____
Address: ____ City, State, Zip: ____
Primary Phone: ____ ❑Home ❑Cell ❑Work Alternate Phone: ____ ❑Home ❑Cell ❑Work
Email: ____ Height: ____ Weight: ____
Allergies: ____ Comorbidities: ____

PRESCRIBER INFORMATION

Prescriber Name: ____ Office Contact: ____
Address: ____ City, State, Zip: ____
Phone: ____ Fax: ____
NPI: ____ DEA: ____

SHIPPING INFORMATION

Ship To: ❑Patient ❑Physician/Clinic ❑Realo Location: ____
Date Shipment Needed By: ____ ❑Alternate Location: ____
Shipping Address City, State, Zip

DIAGNOSIS AND CLINICAL INFORMATION (Please send clinical notes, labs, and/or other supporting documents)

Diagnosis ICD-10: ❑M81.0 Age related Age related osteoporosis without current pathological fracture
❑M81.8 Other osteoporosis without current pathological fracture ❑Other: ____
BMD/T-score: ____ Date: ____ Is patient new to therapy? ❑yes ❑no
History of osteoporotic fracture? ❑yes ❑no If yes, date of fracture: ____ Location of Fracture: ____
If no, is patient at high risk? ❑yes ❑no

Prior Failed Therapies:
❑Actonel® Date(s): ____ ❑Boniva® Date(s): ____ ❑Forteo® Date(s): ____
❑Fosamax® Date(s): ____ ❑Prolia® Date(s): ____ ❑Reclast® Date(s): ____
❑Other: ____ Date(s): ____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	QUANTITY	REFILLS	DIRECTIONS
❑Boniva®	3 mg/3 mL PreFilled Syringe	1 PreFilled Syringe		Inject the contents of 1 syringe (3mg) intravenously every 3 months. To be administered by a healthcare professional
❑Evenity®	105mg/1.17mL Prefilled Syringe	2 PreFilled Syringes		Inject 2 prefilled syringes (210mg) once every month for 12 months
❑Forteo®	600 mcg/2.4 mL pen	1 pen (4 weeks)		Inject 1 dose (20 mcg) subcutaneously once daily. Discard device 28 days after first use. Dispensed with BD MiniTM Pen Needles: (30 needles per 1 pen dispensed)
❑Reclast®	5 mg/100 mL vial	1 vial		Infuse 5 mg intravenously over no less than 15 minutes once annually
❑Tymlos®	1.56 mL	1 box		80 mcg SubQ once daily
❑Pen Needles 31 gauge	❑5mm ❑6mm ❑8mm	4 week supply		Used as directed with pens

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature	Date	Substitution Permissable - Signature	Date

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.

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