

REFERRAL STATUS		
<input type="checkbox"/> NEW REFERRAL	<input type="checkbox"/> DOSE/FREQUENCY CHANGE	<input type="checkbox"/> ORDER RENEWAL

PATIENT INFORMATION
NAME: _____
DATE OF BIRTH: ____/____/____
PHONE: (____) _____-_____
ALLERGIES: _____ _____
WEIGHT: _____LBS HEIGHT: _____IN
PLEASE ATTACH DEMOGRAPHICS, CLINICALS, AND LABS

PROVIDER INFORMATION
NAME: _____
NPI: _____
SIGNATURE: _____
PHONE: (____) _____-_____
FAX: (____) _____-_____
CONTACT PERSON: _____
DATE: ____/____/____ REFILLS: _____
ALL ORDERS ARE VALID FOR ONE YEAR, UNLESS SPECIFIED

MEDICAL INFORMATION (REQUIRED)
<input type="checkbox"/> DEXA SCAN/BMD SCORES ATTACHED (MUST BE -2.5 OR GREATER, OR HAVE FRACTURES DOCUMENTED) <input type="checkbox"/> CALCIUM LEVEL (WITHIN LAST 6 MONTHS) <input type="checkbox"/> RECORDS OF PATIENT BEING ON VITAMIN D/CALCIUM SUPPLEMENTATION

MEDICATION ORDERS																	
<input type="checkbox"/> ZOLEDRONIC ACID/RECLAST 5MG/100ML IV SINGLE DOSE <input type="checkbox"/> EVENITY 210MG SQ MONTHLY FOR ONE YEAR <input type="checkbox"/> PROLIA 60MG SQ ONCE EVERY 6 MONTHS <input type="checkbox"/> BONIVA 3MG IV EVERY 3 MONTHS	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #cccccc;"> <th style="text-align: center; padding: 5px;">DIAGNOSIS</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;"><input type="checkbox"/> M80.0 ____ AGE-RELATED OSTEOPOROSIS WITH CURRENT PATHOLOGICAL FRACTURE</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> M81.0 AGE-RELATED OSTEOPOROSIS W/O CURRENT PATHOLOGICAL FRACTURE</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> M81.8 OTHER OSTEOPOROSIS W/O CURRENT PATHOLOGICAL FRACTURE</td> </tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #cccccc;"> <th style="text-align: center; padding: 5px;">PRE-MEDICATIONS</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">BENADRYL IV _____ MG</td> </tr> <tr> <td style="padding: 5px;">REGLAN IV _____ MG</td> </tr> <tr> <td style="padding: 5px;">SOLUMEDROL IV _____ MG</td> </tr> <tr> <td style="padding: 5px;">ZOFRAN IV _____ MG</td> </tr> <tr> <td style="padding: 5px;">OTHER IV _____ MG</td> </tr> <tr> <td style="padding: 5px;">BENADRYL PO _____ MG</td> </tr> <tr> <td style="padding: 5px;">TYLENOL PO _____ MG</td> </tr> <tr> <td style="padding: 5px;">ZYPREVA PO _____ MG</td> </tr> <tr> <td style="padding: 5px;">ZOFRAN PO _____ MG</td> </tr> <tr> <td style="padding: 5px;">ZANTAC PO _____ MG</td> </tr> <tr> <td style="padding: 5px;">OTHER PO _____ MG</td> </tr> </tbody> </table>	DIAGNOSIS	<input type="checkbox"/> M80.0 ____ AGE-RELATED OSTEOPOROSIS WITH CURRENT PATHOLOGICAL FRACTURE	<input type="checkbox"/> M81.0 AGE-RELATED OSTEOPOROSIS W/O CURRENT PATHOLOGICAL FRACTURE	<input type="checkbox"/> M81.8 OTHER OSTEOPOROSIS W/O CURRENT PATHOLOGICAL FRACTURE	PRE-MEDICATIONS	BENADRYL IV _____ MG	REGLAN IV _____ MG	SOLUMEDROL IV _____ MG	ZOFRAN IV _____ MG	OTHER IV _____ MG	BENADRYL PO _____ MG	TYLENOL PO _____ MG	ZYPREVA PO _____ MG	ZOFRAN PO _____ MG	ZANTAC PO _____ MG	OTHER PO _____ MG
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BY SIGNING THIS FORM AND UTILIZING OUR SERVICES, YOU ARE AUTHORIZING OUR COMPANY (BASED ON PREFERRED LOCATION) AND ITS EMPLOYEES TO SERVE AS YOUR PRIOR AUTHORIZATION AND SPECIALTY PHARMACY DESIGNATED AGENT IN DEALING WITH MEDICAL AND PRESCRIPTION INSURANCE COMPANIES. THE INFORMATION IN THIS TRANSMISSION MAY CONTAIN PRIVILEGED AND CONFIDENTIAL INFORMATION, INCLUDING PATIENT INFORMATION PROTECTED BY FEDERAL AND STATE PRIVACY LAWS. IT IS INTENDED ONLY FOR THE USE OF THE PERSON(S) NAMED ABOVE. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY REVIEW, DISSEMINATION, DISTRIBUTION, OR DUPLICATION OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU ARE NOT THE INTENDED RECIPIENT, PLEASE CONTACT THE SENDER BY REPLY EMAIL AND DESTROY ALL COPIES OF THE ORIGINAL.