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MedRX Infusion
www.medrxinfusion.com

Osteoporosis Referral Form

Administer At: ☐ Patien's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: _____

1. Patient Information

Last Name:_____

First Name:_____

Date of Birth:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

2. Prescriber Information

Prescriber Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

NPI# _____ Office Contact:_____

3. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Allergies:_____ Height:_____ Weight:_____

Tried/Failed Meds and Therapies:_____

Diagnosis (ICD 10 Code):_____

4. Prescription Information

Medication	Dose	Directions	Dispense	Refill
☐ **Boniva** (Ibandronate)	3 mg/3 mL	Infuse 3 mg IV every 3 months	____ infusion	
☐ **Evenity®** (romosozumab-aqqg)	Two-pack carton of 105 mg/1.17 mL prefilled syringes. Total dose 210 mg	Inject 210 mg (two 105 mg syringes sequentially) subcutaneously once every month for 12 doses in the abdomen, thigh or upper arm. Note: Evenity must be administered by a healthcare provider.	☐ 1 carton (2 syringes) ☐ Other_____	
☐ **Forteo®** (teriparatide [rDNA origin])	Multi-dose prefilled Forteo delivery device containing 28 daily doses of 20 mcg	Inject 20 mcg subcutaneously once daily Stop date:_____ ☐ provide pen needles 5 to 8 mm, 31-gauge needles	☐ 1-month supply ☐ 3-month supply	
☐ **Prolia®** (denosumab)	60 mg/1 mL prefilled syringe	Administer 60 mg every 6 months as a subcutaneous injection in the upper arm, upper thigh or abdomen Note: Prolia must be administered by a healthcare provider.	☐ 1 syringe ☐ Other_____	
☐ **Reclast** (Zoledronic Acid)	5 mg IV every 12 months	Infuse 5 mg IV every 12 months	1 infusion	
☐ **Tymlos®** (abaloparatide)	Multi-dose prefilled Tymlos pen delivering 30 daily doses containing 80 mcg of abaloparatide	Inject 80 mcg subcutaneously once daily Stop date:_____ ☐ provide pen needles 5 to 8 mm, 31-gauge needles	☐ 1-month supply ☐ 3-month supply	
☐ **Other**				

Order will include as needed: Anaphylaxis kit, Diluents, Flushes, Supplies. Skilled Home Health nursing services if administered at home

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting)

I authorize MedRX Infusion Clinical Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature PRESCRIBER SIGNATURE REQUIRED. NO STAMPS._____ Date _____