Sterling SPECIALTY PHARMACY

Osteoporosis
Prescription Referral Form

NPI: 1225548480 • Ph: 888.618.4126 • F: 866.588.0371

Note: Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Date Medication Needed:_____ **Ship to:** ❑ Patient's Home ❑ Prescriber's Office ❑ Pharmacy to Coordinate

1 Patient Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical).

Patient Name:_____ Birthdate:_____ Sex: ❑ Male ❑ Female Height:_____ Weight:_____ ❑ lbs. ❑ kg.

Allergies:_____ Patient Primary Language: ❑ English ❑ Spanish ❑ Other:_____ ❑ Hearing Impaired

Patient Phone: _____ Secondary Phone:_____ Patient Email:_____ Caregiver Name:_____

Patient Address:_____ City:_____ State:_____ Zip:_____

2 Provider/Prescriber Information

Clinic Name:_____ Provider Name:_____ DEA#:_____ NPI#:_____

Provider Address:_____ City:_____ State:_____ Zip:_____

Key Contact:_____ Phone:_____ Fax:_____ Email:_____

3 Diagnosis/Clinical Information

Please FAX Clinical Notes, Labs & Tests with the prescription to expedite Prior Authorization.

Diagnosis/ICD-10: _____ Diagnosis Date: _____ Other: _____

Is patient new to therapy? ❑ Yes ❑ No BMD/T-Score: _____ Date: _____

Is patient high risk for fracture? ❑ Yes ❑ No FRAX Score: _____ Date: _____

History of osteoporotic fracture? ❑ Yes ❑ No

If Yes, Location of Fracture: _____ Date of Fracture: _____

Contraindication(s) to bisphosphonate therapy? ❑ Yes ❑ No

If Yes: ❑ Dysphagia ❑ GERD ❑ Ulcer ❑ Other: _____

Please Attach All Medical Documentation, Including:

❑ DEXA Scan ❑ Medication History ❑ CMP Panel ❑ Other Information Pertinent to the Case

Labs: Calcium: _____ Vitamin D: _____ Date: _____

Injection Training: ❑ Pharmacist to Provide ❑ Patient Trained in MD Office

Prior Failed Treatments:	Drug Name & Length of Treatment:
❑ Actonel®	
❑ Boniva®	
❑ Forteo®	
❑ Fosamax®	
❑ Prolia®	
❑ Reclast®	
❑ Other	

If Prior Authorization is Denied: Sterling will inform provider of preferred formulary alternatives and/or draft an appeal letter as advisable.

4 Prescription Information

Please be sure to choose both induction and maintenance dose where applicable.

Patient Name:_____ Patient Birthdate:_____

Medication	Dose/Strength	Direction	Qty.	Refills
❑ FORTEO®	❑ 600mcg/2.4ml Pen	❑ Inject 20mcg SC once daily ❑ _____	❑ 1 ❑ _____	
❑ PROLIA®	❑ 60mg/ml Prefilled Syringe	❑ Inject 60mg SC every 6 months ❑ _____	❑ 1 ❑ _____	
❑ TYMLOS™	❑ 3,120mcg/1.5ml Prefilled Pen	❑ Inject 80mcg SC once daily ❑ _____	❑ 1 ❑ _____	
❑ _____	❑ _____	❑ _____	❑ _____	___
❑ _____	❑ _____	❑ _____	❑ _____	___
❑ _____	❑ _____	❑ _____	❑ _____	___

Prescriber Signature: Prescriber, please sign and date below (**NO stamps please**):

Dispense as written:_____ Date:_____ Substitution Permissible: _____ Date:_____

I authorize Sterling Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services, and patient assistance programs.

# of Prescriptions:_____