Sterling SPECIALTY PHARMACY

Osteoporosis Prescription Referral Form

888.618.4126 • Fax: 866.588.0371
www.sterlingspecialtyrx.com

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.

Primary Phone: _____ Secondary Phone: _____ Allergies: _____

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

Patient Email: _____ Caregiver Name: _____

2 Prescriber Information

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

Address: _____ Phone: _____ Fax: _____

City, State, Zip: _____ Key Contact: _____

3 Diagnosis/Clinical Information

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

Date of Diagnosis: _____ ICD-10: _____ 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? ❑No ❑Yes

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 ❑Manufacturer Nurse Support

If Prior Authorization is Denied: ❑Automatically Draft Appeal for Review ❑Send Preferred Formulary Alternatives

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

4 Prescription Information

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dose/Strength	Direction	Qty.	Refills
❑ FORTEO®	❑ 600mcg/2.4ml Pen	❑ Inject 20mcg SC once daily	1	
❑ PEN NEEDLES	❑ 31 Gauge ❑ 5mm		100	
❑ PROLIA®	❑ 60mg/ml Prefilled Syringe	❑ Inject 60mg SC every 6 months	1	
❑ TYMLOS™	❑ 3,120mcg/1.5ml Prefilled Pen	❑ Inject 80mcg subcutaneously once daily into the periumbilical region of the abdomen	1	
❑ PEN NEEDLES	❑ 31 Gauge ❑ 8mm		100	
❑ _____	_____	_____		

Prescriber Signature: Prescriber, please sign and date below:

Dispense as written: Date: Substitution Permissable: 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: _____