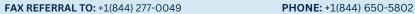
Osteoporosis REFERRAL FORM





_	PATIENT 3 II	NFORMATI	Complete of	r include demographic she	eet)			
	Patient Name:			DOB:	G	iender: MALE	FEMALE	
				City/State/Zip:				
	Primary Phone:	ary Phone: Email:		SSN: Primary		/ Language:		
	Emergency Contact:	nergency Contact:		Relationship to Patient: Phone: _				
2	INSURANCE (Please attach If Available a copy of the Patients' insurance card(s) Front/ Back)							
	Primary Insurance:							
	Primary RX Insurance:	nary RX Insurance:ID No:		RX GRP: RX BIN:		RX PCN:		
3	DIAGNOSIS AND CLINICAL INFORMATION							
	First time receiving Immuno		Yes No If No, p	s No If No, previous product used:			_ Last Dose Given:	
	Drug Allergies:	_		NKDA H	t: i	n/cm Wt:	lhs/Kø	
					<u></u> -	,		
	Diagnosis (ICD-10): M80.0 Age related osteoporosis with current pathological fracture M81.0 Age Related osteoporosis W/O current pathological fracture Other:							
Labs: Please fax copy of the following labs dated within 1 year of the patients referral request: ☐CMP ☐CBC w/ diff ☐SCr or eGFR ☐ Calcium Level(s) ☐ Mg and P (if SCr < 30) ☐ Vitamin-D ☐ iPTH ☐ Dex							SCAN	
1	4 Access: M Subcutaneous							
-	_			DOCE & DIRECTION		OLIANITITY	DEFILI	
	MEDICATION	STRENGTH		DOSE & DIRECTION		QUANTITY	REFILL	
	■ Evenity	105 mg/ 1.17 mL		nsecutive subcutaneous i lose of 210 mg once mon	,	Quantity: Q.S	Refills:	
	Forteo	600 mcg/2.4 mL	Inject 20 mcg	(0.08 mL) subcutaneous	ly once daily.	Quantity: Q.S	Refills:	
	Prolia	60 mg	Inject 60 m	g subcutaneously every	6 months.	Quantity: Q.S	Refills:	
	Teriparatide **Latex Free**	600mcg/2.4mL	Inject 20 mcg	(0.08 mL) subcutaneousl	ly once daily.	Quantity: Q.S	Refills:	
	Teriparatide	620 mcg/2.48 mL	Inject 20 mcg	(0.08 mL) subcutaneousl	ly once daily.	Quantity: Q.S	Refills:	
	Other:					Quantity: Q.S	Refills:	
ANAPHYLAXIS PROTOCOL:								
	MEDICATION DIRECTION					QUANTITY	REFILLS	
	EDINEDUDINE (autoticio atom)		•	y repeat in 5-15 minutes				
EPINEPHRINE (autoinjector) 0.3 mg (Wt > 30 kg) 0.15 mg (Wt 15-30 kg) 0.1 mg (Wt 7.5-15 kg)						Quantity: (x2) Pen(s)	Refills: PRN	
NURSING/ INFUSION SUPPLIES:								
	NURSING: Nursing visits with	onitor patient, and pro	vide education.					
	INFUSION SUPPLIES: Infusion			edication.				
5	PRESCRIBER	INFORMA	TION					
	rescriber Name: Title: MD DO ND PA APRN NPI:							
		City/ State/ Zip:						
	Phone: Fax: Contact Person:							
	The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX. CONFIDENTIALITY NOTICE: The information contained in this transmission may contain 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 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 to info@ivsolutionsrx.com and destroy all copies of the original message.							
			Prescribe	ers Signature		Date		