# Osteoporosis
## REFERRAL FORM

**FAX REFERRAL TO:** +1(844) 277-0049 **PHONE:** +1(844) 650-5802

IV Solutions RX

## 1 PATIENT'S INFORMATION *(Complete or include demographic sheet)*

**Patient Name:** _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE
**Address:** _____ **City/State/Zip:** _____
**Primary Phone:** _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____
**Emergency Contact:** _____ **Relationship to Patient:** _____ **Phone:** _____

## 2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

**Primary Insurance:** _____ **Policy No:** _____ **Group:** _____
**Primary RX Insurance:** _____ **ID No:** _____ **RX GRP:** _____ **RX BIN:** _____ **RX PCN:** _____

## 3 DIAGNOSIS AND CLINICAL INFORMATION

**First time receiving Immunoglobulin Therapy?** ☐ Yes ☐ No **If No, previous product used:** _____ **Last Dose Given:** _____

**Patient Clinical Information:**

**Drug Allergies:** _____ ☐ NKDA **Ht:** _____in/cm **Wt:** _____lbs/Kg

**Diagnosis (ICD-10):**
☐ M80.0 Age related osteoporosis with current pathological fracture ☐ M81.0 Age Related osteoporosis W/O current pathological fracture
☐ Other: _____ Description: _____

**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** ☐ **Dexa-SCAN**

## 4 Access: ☒ Subcutaneous

| MEDICATION | STRENGTH | DOSE & DIRECTION | QUANTITY | REFILL |
|---|---|---|---|---|
| ☐ **Evenity** | 105 mg/ 1.17 mL | Administer two consecutive subcutaneous injections (105 mg each) for a total dose of 210 mg once monthly for 12 doses | Quantity: **Q.S** | Refills: _____ |
| ☐ **Forteo** | 600 mcg/2.4 mL | Inject 20 mcg (0.08 mL) subcutaneously once daily. | Quantity: **Q.S** | Refills: _____ |
| ☐ **Prolia** | 60 mg | Inject 60 mg subcutaneously every 6 months. | Quantity: **Q.S** | Refills: _____ |
| ☐ **Teriparatide** ***Latex Free*** | 600mcg/2.4mL | Inject 20 mcg (0.08 mL) subcutaneously once daily. | Quantity: **Q.S** | Refills: _____ |
| ☐ **Teriparatide** | 620 mcg/2.48 mL | Inject 20 mcg (0.08 mL) subcutaneously once daily. | Quantity: **Q.S** | Refills: _____ |
| ☐ **Other:** _____ | _____ | _____ | Quantity: **Q.S** | Refills: _____ |

**ANAPHYLAXIS PROTOCOL:**

| MEDICATION | DIRECTION | QUANTITY | REFILLS |
|---|---|---|---|
| ☐ EPINEPHRINE **(autoinjector)** | Administer IM for anaphylactic reaction. May repeat in 5-15 minutes severe ☐ ***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 each infusion to establish Subcutaneous administer medication, assess and monitor patient, and provide education.
☐ **INFUSION SUPPLIES:** Infusion supplies for the administration and disposal of medication.

## 5 PRESCRIBER INFORMATION

**Prescriber Name:** _____ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:** _____
**Address:** _____ **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.

_____ _____
**Prescribers Signature** **Date**

**THANK YOU FOR YOU TRUSTING US IN YOUR PATIENTS SPECIALTY CARE** *#welcome to our family*


5315 Avion Park Drive, Suite 120 Tampa, Florida 33607