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
☐ **BONSITY®** *(teriparatide)*	560 mcg/ 2.24 mL	Inject 20 mcg (0.08 mL) subcutaneously once daily.	Quantity: **Q.S**	Refills: _____
☐ **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/mL	Inject 60 mg subcutaneously every 6 months.	Quantity: **Q.S**	Refills: _____
☐ **Jubbonti** *(denosumab-bbdz)*	60 mg/mL	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: _____
☐ **Tymlos**	3120mcg/1.56mL	Inject 80 mcg (0.052 mL) subcutaneously once daily.		
☐ **STOBOCLO®** *(denosumab-bmwo)*	60 mg/mL	Inject 60 mg subcutaneously every 6 months.	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 SIGNATURE REQUIRED *(STAMP SIGNATURE NOT ALLOWED)*

Prescriber Name: _____ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:** _____
Address: _____ **City/State/Zip:** _____
Phone: _____ **Fax:** _____ **Contact Person:** _____

☐ **DISPENSE AS WRITTEN** ☐ **BRAND MEDICALLY NECESSARY** ☐ **DO NOT SUBSTITUTE** ☐ **NO SUBSTITUTION /** ☐ **DAW /** ☐ **MAY NOT SUBSTITUTE**	☐ **May Substitute /** ☐ **Product Selection Permitted /** ☐ **Substitution Permissible**
Prescriber's Signature: _____ **Date:** _____	**Prescriber's Signature:** _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

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.

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