BERGEN AVE DRUGS
Specialty Pharmacy

OSTEOPOROSIS PRESCRIPTION REFERRAL FORM

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Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

Last updated: May 2017

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

ICD-10 Diagnosis Code Allergies BSA m^2

Patient currently on therapy ☐ Yes ☐ No Date of diagnosis **INSURANCE INFORMATION** Please fax copy of insurance card (front & back)

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

Clinical Information

☐ Yes ☐ No Is the patient unable to remain in an upright position during post oral bisphosphonate administration?

☐ Yes ☐ No Does the patient have documented treatment failure after an adequate trialof at least two oral bisphosphonates?

If yes, please check all that apply: ☐ Fosamax or Fosamax plus D (alendronate) ☐ Didronel (elidronate) ☐ Skelid (tiludronate)
☐ Actonel or Actonel with Calcium or Atelvia (risedronale) ☐ Oral Bonlva (ibandronate) ☐ Other

☐ Yes ☐ No Does the patient have documented treatment failure after an adequate trialof at least one oral bisphosphonate and one SERM?

If yes, please check all that apply: ☐ Fosamax or Fosamax plus D (alendronate) ☐ Didronel (elidronate) ☐ Skelid (tiludronate)
☐ Actonel or Actonel with Calcium or Atelvia (risedronale) ☐ Oral Boniva (ibandronate) ☐ Other
☐ Tamoxifen (nolvadex) ☐ Evista (raloxifene) ☐ Femara (letrozole) ☐ Fareston (toremlfene)

☐ Yes ☐ No Does the patient have a documented medical reason (intolerance, hypersensitivity,and/or contraindication) to avoid using oral bisphosphonates or SERMS?

☐ Yes ☐ No Does the patient have Dysphagia (difficulty swallowing)?

Please check or list all indications that apply to this patient: **If any of these are checked, please refer to the product package insert for appropriate indications, warnings, and contraindications.**

☐ Presence or history of osteoporotic vertebral compression fracture and/or hip fracture
☐ Currently taking calcium and Vitamin D ☐ BMD greater than -2.5 ☐ BMD -1.0 and -2.5 ☐ Other

PRESCRIPTION

☐ **Boniva** ☐ **Forteo** ☐ **Other**

☐ **Reclast** ☐ **Prolia** ☐ **Other**

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Dosage
SIG
QTY **Refills**

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS) **Date**