Osteoporosis Referral Form

THE HONOLULU PHARMACY
COMPOUNDING PHARMACY & SPECIALTY PHARMACY

Phone: 808-533-8887
Fax: 808-533-1888
E-Prescribing Available

Attention: _____ Need By Date: _____ First Ship To: ☐ Patient ☐ Physician

Patient

Patient Name:_____ DOB: _____ Sex: ☐ Male ☐ Female

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

Home#: _____ Work #: _____ Cell#: _____ Best time to call: ☐ AM ☐ PM

Soc. Sec #: _____-_____-_____ Ethnicity: _____ Primary Language: _____

Comorbidities: _____ Height: _____ Weight:_____ Date:_____

Allergies: _____ ☐ NKDA

Provider

Physician Name:_____ Practice Name:_____ State Lic#: _____ DEA#: _____

Address:_____ City:_____ State:_____ Zip:_____ NPI#: _____

Phone#: _____ Fax#: _____ Nurse/Key Office Contact: _____ Ext.: _____

Insurance

Primary Insurance: _____ ID: _____ Phone: _____

Secondary Insurance: _____ ID: _____ Phone: _____

* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

Clinical Info

Diagnosis/ICD-10:

- ☐ M81.0 Osteoporosis, unspecific
- ☐ M81.0 Senile osteoporosis
- ☐ M81.8 Idiopathic osteoporosis
- ☐ M81.8 Disuse osteoporosis
- ☐ M81.8 Other osteoporosis
- ☐ Z79.51 Long-term (current) use of inhaled steroids
- ☐ Z79.52 Long-term (current) use of systemic steroids
- ☐ Other: _____

BMD/T-score: _____

date: _____

Is patient new to therapy? (☐ Y / ☐ N)

History of osteoporotic fracture? (☐ Y / ☐ N)

If yes, date of fracture: _____

Location of fracture: _____

If no, is patient at high risk? (☐ Y / ☐ N)

Prior failed therapies:

- ☐ Actonel® date(s): _____
- ☐ Boniva® date(s): _____
- ☐ Forteo® date(s): _____
- ☐ Fosamax® date(s): _____
- ☐ Prolia® date(s): _____
- ☐ Reclast® date(s): _____
- ☐ Other: _____ date(s): _____

Prescription

Medication	Strength	Directions	Quantity	Refill
☐ **Boniva®**	3 mg/3 mL PreFilled Syringe	Inject the contents of 1 syringe (3mg) intravenously every 3 months. To be administered by a healthcare professional	1 PreFilled Syringe	
☐ **Forteo®**	600 mcg/2.4 mL pen	Inject 1 dose (20 mcg) subcutaneously once daily. Discard device 28 days after first use. Dispensed with BD Mini™ Pen Needles: (30 needles per 1 pen dispensed)	1 pen (4 weeks)	
☐ **Prolia®**	60 mg/1 mL PreFilled Syringe	Inject the contents of 1 syringe (60 mg) subcutaneously every 6 months	1 PreFilled Syringe	
☐ **Other**				

Injection Training

☐ Patient had received injection training ☐ Physician office to provide injection training ☐ THP to coordinate injection training

Physicians Signature: _____ Date: _____

I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.