OSTEOPOROSIS
Referral Form

Phone: (818) 390-9696 • Toll-Free: (855) 265-7850 • Fax: (855) 450-6717 • info@MedicoRx.com

Today's Date: _____ Needs By Date: _____ SHIP TO: ❑ Patient ❑ Office ❑ Other_____

PATIENT INFORMATION		PRESCRIBER INFORMATION	
PATIENT NAME		**PRESCRIBER NAME**	
ADDRESS		**NPI#**	
CITY, STATE, ZIP		**DEA#**	**LICENSE#**
MAIN PHONE#	**ALT.#**	**ADDRESS**	
SOCIAL SECURITY#		**CITY, STATE, ZIP**	
DATE OF BIRTH	**❑ MALE ❑ FEMALE**	**PHONE#**	**FAX#**
HEIGHT	**WEIGHT ❑ LBS ❑ KG**		
ALLERGIES		**CONTACT PERSON**	
OTHER MEDICATIONS			

CLINICAL INFORMATION

Primary Diagnosis _____**Please include Dx Code # and description Prior Failed Meds:

PRESCRIPTION INFORMATION

PATIENT MEDICAL HISTORY ICD-10 CODE:	Prior Failed Medications Duration
Date of Osteoporosis diagnosis	Fosamax (alendronate)
DEXA T-score (worst sites)	Actonel (risdronate)
Previous Fracture(s) ❑ Yes ❑ No	Miacalcin Nasal Spray
Site of Fracture(s)	Boniva
Others:	Reclast

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❑ Forteo	❑ 600mcg/2.4mL Pen	❑ Inject 1 dose (20mcg) subcutaneously once daily. Discard device 28 days after first use.	❑ 1 pen (4-week supply) ❑ 3 pens (12-week supply)	
❑ BD Mini Pen Needles	❑ 31Gx3/16"	❑ Use with Forteo pen once daily as directed	❑ #90 pen needles ❑ #30 pen needles	
❑ Prolia	❑ 60mg/1mL vial	❑ Inject the contents of 1 syringe (60mg) subcutaneously every 6 months	❑ 1 prefilled Syringe	
❑ Reclast	❑ 5mg/100mL vial	❑ Infuse 5mg intravenously over no less than 15 minutes once annually.	One: 5mg/100mL vial	
❑ Boniva	❑ 3mg/3mL PFS	❑ Inject the contents of 1 syringe (3mg) intravenously every 3 months. To be administrated by a healthcare professional	One: 3mg/3mLPFS	

❑ Patient has received pen and injection training ❑ Physician's office to provide injection training

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

By signing this form and utilizing our services, you are authorizing MedicoRX and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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Prescriber's Signature (no stamps) If Brand required check ❑ DAW_____ Initials_____ Date