



866 413-3156 toll free phone
 877 834-1231 toll free fax
 QUESTIONS? Please contact us!
 www.REPharmacy.com

Prolia Referral Form

Send your Rx to:

Date Medication Needed: _____ Ship To: () Patient's Home () Prescriber's Office () Pick-up (store location): _____ Injection training by pharmacy? _____

1. Patient Information

Patient Name: _____ Birthdate: _____ Sex: () Male () Female Height: _____ Weight: _____ () lbs. () kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Alternate Caregiver Name: _____ Preferred Phone: _____
 Date Shipment Needed: _____ Email: _____ Patient education kit? () Yes () No
 Ship to: Patient Physician Other _____ Teaching to be done at: Physician office Patient home (to be coordinated with RE Pharmacy)

2. Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Insurance provider: (please include copy of card) _____ ID#: _____ Policy group#: _____ PCN#: _____
 Name of insured: _____ Phone: _____ Fax: _____
 Employer: _____ Relationship to patient: Self Other: _____
 Carrier: _____ Policy group#: _____ Patient is eligible for Medicare Prescription Card: () Yes () No

3. Prescriber Information

Prescriber Name: _____ State Lic.: _____ DEA#: _____ NPI#: _____
 Address: _____ Phone: _____ Fax: _____
 City, State, Zip: _____ Key Contact: _____ Phone: _____

4. Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

M81.8 Osteoporosis, unspecified M80.00 Senile Osteoporosis, Postmenopausal Osteoporosis
 Other (specify ICD-10) _____
 T-Score (if known): _____
 History of Osteoporosis fracture: () Yes () No () Not Known Skeletal Site (If known): _____
 Other risk factors for Osteoporosis fracture (if any): _____
Prior Postmenopausal Osteoporosis Treatment History (if any):
 Generic alendronate Fosamax (alendronate sodium) Actonel (risedronate sodium) Boniva (ibandronate sodium) Other: _____
 Reason for discontinuing previous osteoporosis therapies: _____
 Contradictions (if any): _____
 Other pertinent medical information (ex: calcium and vitamin D supplementation): _____

5. Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
Prolia	60mg prefilled syringe	60mg SC every six months		

Notes:

6. Prescriber Signature

Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written

Date

Substitution Permissible

Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/NT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

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