RE PHARMACY
PASSION FOR LIFE

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:
Select Location

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: _____
Soc. Sec. #: _____ Preferred Phone: _____
Address: _____
Alternate Caregiver Name: _____
Date Shipment Needed: _____
Ship to: ☐ Patient ☐ Physician ☐ Other _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ☐ lbs. ☐ kg.
Known Allergies: _____
City: _____ State: _____ Zip: _____
Preferred Phone: _____
Email: _____ Patient education kit? ☐ Yes ☐ No
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) _____
Name of insured: _____
Employer: _____
Carrier: _____ Policy group#: _____

ID#: _____ Policy group#: _____ PCN#: _____
Phone: _____ Fax: _____
Relationship to patient: ☐ Self ☐ Other: _____
Patient is eligible for Medicare Prescription Card: ☐ Yes ☐ No

3. Prescriber Information

Prescriber Name: _____ State Lic.: _____
Address: _____
City, State, Zip: _____

DEA#: _____ NPI#: _____
Phone: _____ Fax: _____
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 (ibanronate 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** _____

# of Prescriptions: _____

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