



CEDRA

OSTEOPOROSIS

REFERRAL FORM

FAX: 888 889 7129

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CEDRASPECIALTY.COM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Preferred Phone: _____
 SSN#: _____ Language: English Other _____
 Address: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 City: _____ State: _____ Zip: _____ Known Allergies: _____

*** PLEASE FAX FRONT/BACK COPY OF PHARMACY BENEFIT CARD, MEDICAL INSURANCE CARD, NOTES, LABS & TESTS WITH THE PRESCRIPTION TO EXPEDITE PROCESSING ***

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: _____ E-mail: _____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: _____ Fax: _____
 STATUS UPDATE PREFERENCE: Phone Text Fax E-mail: _____

DIAGNOSIS/CLINICAL INFORMATION

Diagnosis
 M88.9 Paget's Disease M80.80 Unspecified Osteoporosis M81.0 Postmenopausal/Senile Osteoporosis M81.8 Drug-induced Osteoporosis
 M80.88 Pathological Fracture of Vertebrae M80.85 Pathological Fracture of Neck of Femur M89.9 Unspecified disorder of bones M94.9 of cartilage

Date of Diagnosis: _____
 Patient Evaluation - General
 Treatment History: New to this Medicine Continued Treatment
 NOTE: If continuing on FORTEO®, what is start date of treatment? _____ (FORTEO® can be taken for a maximum of 24 months)
 Allergies: None Latex Other (please specify) _____
 Concomitant Medications: _____
 Patient Evaluation - Osteoporosis
 Lowest DEXA T-Score: _____ Date of DEXA: _____
 Fracture Site (if approp): _____ Date of fracture: _____
 Prior Failed Medication(s) _____ Length of Treatment _____ Reasons for Discontinuation _____

PRESCRIPTION INFORMATION

| MEDICATION | DOSE/STRENGTH | SIG | QTY. | REFILLS |
|-----------------|---|--|-------------------------------|---------|
| ACTONEL® | mg tablets | | | |
| BONIVA® | Prefilled Syringe (3mg/3ml) 150 mg tablet | Inject 3mg IV over 15-30 seconds every 3 months 1 tablet once monthly, taken at the same date each month | 1 Syringe (3mg/3ml) | |
| FORTEO® | Pen (600ug/2.4ml) Delivery Device Complimentary Needles 4mm 32G 5mm 31G 8mm 31G | Inject 20mcg (0.08ml) SQ daily (FORTEO® can be taken for a maximum of 24 months) Use with FORTEO® Delivery Device as directed | 1 Pen (600ug/2.4ml) 30 | |
| FOSAMAX® | 35 mg tablets 70 mg tablets | 1 tablet once weekly | | |
| PROLIA® | Prefilled Syringe (60mg/ml) | Inject 60mg SQ once every 6 months | 1 Pen (60mg/ml) | |
| TYMLOS™ | Prefilled Pen 3120 mcg/1.56 mL (2000 mcg/mL) | Recommended dose is 80 mcg subcutaneously once daily; patients should receive supplemental calcium and vitamin D if dietary intake is inadequate. Administer as a subcutaneous injection into periumbilical region of abdomen. Administer initially where the patient can sit or lie down in case symptoms of orthostatic hypotension occur. | 1 Syringe (3mg/3ml) | |
| ZOLEDRONIC ACID | Vial (5mg/100ml) | Infuse 5mg IV, over no less than 15 minutes, every year Infuse 5mg IV, over no less than 15 minutes, every 2 years | 1 Vial (5mg/100ml) | |
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COMMENTS:

INJECTION TRAINING

Patient has received pen and injection training Enroll patient in manufacturer-sponsored training program
 Date Medication Needed: _____ Deliver To: Patient Home MD Office
 Prescriber Signature: (Please sign and date below) _____
 Your signature authorizes Cedra Pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.
 Substitution Permissible _____ Date _____ Dispense as written "DAW" _____ 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. 374_OsteoRef100-02NY-B

