EL NORTE
Retail & Specialty Pharmacy

OSTEOPOROSIS REFERRAL FORM

Phone: (760) 233-2100
Fax: (760-233-2105

Ship To: ❑ Patient ❑ Physician / Clinic ❑ Pick Up ❑ Date Needed:_____ **Injection Training Needed:** ❑ Yes ❑ No

PATIENT INFORMATION					PRESCRIBER INFORMATION	
	Patient Name				**Prescriber Name**	
	Address				**NPI**	
	City, State, Zip				**Address**	
	Primary Phone		**Alt. Phone**		**City, State, Zip**	
	Date of Birth		**Allergies**		**Office Phone:**	
	Height/ Weight		**Sex:**	❑ Male ❑ Female	**Office Fax:**	
	Insurance	**PLEASE FAX A COPY OF INSURANCE CARD(S)**			**Contact Person**	

CLINICAL INFORMATION

Diagnosis: ❑ Age related osteoporosis without current pathological fracture ❑ Other osteoporosis without current pathological fracture ❑ Other: _____

Does patient have renal impairment? ❑ Yes ❑ No CrCL: _____ Dexa Scan T-Score: _____ Location: _____ Date: _____

Tried/Failed Previous Therapies: Bisphosphonates: ❑ Yes ❑ No Please List: _____ If no, please explain why: _____
Other: ❑ Yes ❑ No Please List: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/ STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❑ **FORTEO**	❑ 600 mcg/2.4mL	❑ Inject 20mcg (0.08mL) subcutaneously once daily		
❑ **PROLIA**	❑ 60 mg	❑ Inject 60mg subcutaneously once every 6 months		
❑ **TYMLOS**	❑ 3120 mcg/1.56mL	❑ Inject 80mcg (0.04mL) subcutaneously once daily		
❑ **PEN NEEDLES**	❑ 5mm ❑ 6mm ❑ 8mm	❑ Use as directed daily with Forteo / Tymlos pen		
❑ **OTHER**	❑	❑		

By signing below, I authorize El Norte Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and help the patient to apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ Date: _____