Pharmax SPECIALTY PHARMACY

OSTEOPOROSIS REFERRAL FORM

TEL 813.880.2500
FAX 813.880.2501
TOLL FREE 1.866.880.2507

PATIENT INFORMATION

Name:_____ Address:_____ _____ _____ Phone:_____

SSN:_____ DOB:_____ Sex:_____

Weight:_____ Height:_____ Allergies:_____ Ship to: ☐ Patient ☐ Clinic

INSURANCE

Prescription Card: _____ Name of Insurer:_____ ID#_____ BIN:_____ PCN:_____

Group:_____ (Please attach copies of insurance cards.)

DIAGNOSIS

ICD-9: _____ Prior Failed Therapy:_____ Start Date: _____ End Date: _____

Reason For DC: _____

Current Medications:_____

TEST RESULTS

Serum Calcium_____ SCr:_____ BMD:_____

T Score: _____ Fracture History: _____

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refill
☐ Boniva				
☐ Forteo	☐ 600 mcg/2.4ml	☐ Inject 20 mcg SC Once Daily		
☐ Prolia	☐ 60 mg/ml			
☐ Bd Pen Needles				
☐ Other				

PRESCRIBER INFORMATION

Physician Name:_____ Address:_____

State License#:_____ NPI:_____ DEA:_____

Phone #:_____ Fax #:_____ Office Contact Name /Number:_____

Prescriber's Signature:_____ Date:_____

I authorize pharmax specialty pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.