KINGS CARE
PHARMACY | FARMACIA

OSTEOPOROSIS
REFERRAL FORM

FAX: 718-684-1598
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KINGSCARESPECIALTY.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)	
☐				
☐				
☐				

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 Kings Care 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

PCAB ACCREDITED Compounding Pharmacy | urac ACCREDITED

SUBMIT FORM CLEAR FORM