Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to pharmacy.

Osteoporosis

Referral for Medication and Patient Management Program

OptiMed
6480 Technology Ave., Suite A | Kalamazoo, MI 49009
Phone: 877.385.0535
Fax: 877.326.2856

Please fax a copy (front and back) of all the patient's pharmacy and medical insurance cards as well as any relevant clinical notes/documents

Patient Demographics

Name _____ Sex ☐M ☐F
DOB _____ SSN _____
Phone _____ 2nd Phone _____
Address _____ Apt/Suite _____
City, State, ZIP _____
Primary language, if other than English _____

Provider Information

Prescriber _____
NPI _____ DEA _____
Practice Name _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____ Key contact _____

This is a ☐ New Rx ☐ Refill

Training by ☐ Prescriber's office ☐ Not needed ☐ Pharmacy to facilitate

Ship to / Site of Care ☐ Prescriber's office ☐ Patient (Forteo and Tymlos only) ☐ OptiMed Infusion Center ☐ Other _____

Clinical Information

Diagnosis (include ICD-10 code) _____
Weight _____ ☐ lb ☐ kg **Height** _____ ☐ in
Allergies _____
_____ **Latex allergy?** ☐Yes ☐No
Prior treatments & reason for discontinuation _____
_____
_____
_____

BMD/T-score _____ **Date** _____
Serum calcium level** _____ **Date** _____
Is patient at risk for osteoporotic fracture as evident by any of the following?
☐ History of osteoporotic fracture Site _____ Date _____
☐ Patient has tried and failed oral bisphosphonate
☐ Patient has documented contraindication/is intolerant to oral bisphosphonate therapy
☐ Other _____

Please submit a copy of DEXA and serum calcium level with prescription

	Medication	Directions	Quantity	Refills
Antiresorptive	☐ **Prolia®** 60mg * (denosumab)	Inject 60mg subcutaneously every 6 months.	1 syringe (180-day supply)	_____
	Administration by a healthcare professional only. Ship to Provider Office or administer at OptiMed Ambulatory Infusion Center as indicated above. ***Serum Calcium level required within 30 days of onsite injection.***			
Anabolic	☐ **Evenity™** 105mg * (romosozumab-aqqg)	Inject 210mg (2 syringes) subcutaneously once monthly. **Limit duration of use to 12 monthly doses**	2 syringes (30-day supply)	_____
	Administration by a healthcare professional only. Ship to Provider Office or administer at OptiMed Ambulatory Infusion Center as indicated above. ***Serum Calcium level required within 30 days of onsite injection.***			
	☐ **Forteo®** multi-dose pen (teriparatide)	Inject 20mcg subcutaneously once daily.	1 pen (28-day supply)	
	with **pen needles**	Use a new pen needle daily for Forteo® injection.	1 box (30 needles)	_____
	☐ *Check here to enroll the patient into Forteo® Connect ongoing support.*			
	☐ **Tymlos®** multi-dose pen (abaloparatide)	Inject 80mcg subcutaneously once daily.	1 pen (30-day supply)	
	with **pen needles**	Use a new pen needle daily for Tymlos® injection.	1 box (30 needles)	_____
	☐ Other Medication			
	Drug _____	☐ _____	☐ _____	_____

Please note: To increase adherence and patient acceptance all medications will be dispensed as pen type injectors unless unavailable or otherwise specified.

Provider Signature _____ **Date** _____

My signature for this prescription confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies if necessary, in conjunction with the therapy prescribed above.

V121919A

CLEAR FORM