

PROLIA REFERRAL FORM

PATIENT INFORMATION (Complete the following or send patient's demographic sheet)

Last Name _____ First Name _____ Sex M F _____ Date of Birth _____
Address _____ Home Phone _____ Work/Mobile Phone _____
Medicare # _____ Medical # _____ Other _____ Facility _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD-10 code):

- M81.0 Age-related osteoporosis without current pathological fracture
- M80.0 Age-related osteoporosis with current pathological fracture Other: _____
- Is Patient pregnant, nursing, or planning pregnancy? Yes No N/A | Allergies: _____

Patient Evaluation:

- Is the patient currently taking a bisphosphonate? Yes No
If Yes, will current bisphosphonate therapy be discontinued? Yes No
- Patient is currently taking Calcium and Vitamin D Supplements Yes No
- Does the patient have hypocalcemia? Yes No • Patient's Weight: _____ Kgs/lbs.
- Is the patient at the risk of fracture? Yes No • Patient's height: _____ inches

Bone Mineral density Results:

- DXA Results (g/cm²): _____ T-Score: _____ Date: _____

Prior Failed Medications:

- Generic Alendronate Fosamax Actonel Boniva Other _____
- Reason for discontinuation of other therapy(ies) _____
- Contraindications (if any) _____

PRESCRIPTION INFORMATION

MEDICATION	DIRECTIONS	QUANTITY	REFILL
<input type="checkbox"/> PROLIA	Inject 60mg SubQ every 6 months	1	_____

Prescriber Certification: I certify the above therapy is medically necessary and that the information above is accurate to the best of my knowledge I authorize the Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: X _____ Date: _____ Office contact: _____

Physician Name: _____ UPIN # _____ NPI # _____ DEA# _____

Physician Address: _____ Phone # _____ Fax _____

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake. Then destroy this document. Please direct all verification or notification to the above mentioned physician's office.

By signing this document you authorize Southside pharmacy to contact insurance companies for prior authorization purposes.



FAX TO : (855) 822-7838

Specialty Pharmacy | IV Therapy | Home Health | Medical Equipment | Physicians billing

7700 Main St., Houston, TX 77030 | P: (855) 822-7828 | www.ssr.com

"One SOURCE for ALL your Medical NEEDS"