ENDOCRINOLOGY REFERRAL FORM

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

_____ Sex □M □F _____
Last Name First Name Date of Birth

_____ _____ _____
Address Home Phone Work/Mobile Phone

_____ _____ _____ _____
Medicare # Medical # Other Facility

TREATMENT ARRANGEMENTS

• Start Date:_____ Ship Meds □ Home □ Doctor's Office •Teaching by: □ Home Health □ Doctor's Office □ Other:_____

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD-10 code): □ M81.0 Osteoporosis □ E11.9 Non Insulin DM □ E10.9 Insulin DM □ E11.65 Insulin DM

- Is Patient using prescribed therapy in combination with other biologics for MS? □ Yes □ No
- 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 upon induction of FORTEO? □ 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: _____
- DXA Results (g/cm2):_____ T-Score: _____ Date: _____

Prior Failed Medications: **Duration/Reason of Discontinuation**

_____ _____
_____ _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
□ TYMLOS	□ 3120mcg/1.56ml	Inject 80mcg SubQ once daily	30days	_____
□ FORTEO	□ 600mcg/2.4ml Device	Inject 20mcg (0.08ml) SubQ once daily	_____	_____
□ PROLIA		Inject 60mg SubQ every 6 months	_____	_____
□ RECLAST	□ 5mg	Infuse 5mg IV once a year	1 vial	_____
□ GLUMETZA ER	□ 500 mg □ 1000 mg	Take one tablet by mouth once a day	_____	_____
□ SAXENDA	□ 18 mg/3 ml PEN	Inject 3mg SubQ everyday	_____	_____

Physician Signature: _____ Date:_____Office contact:_____

Physician Name:_____ UPIN #_____ NPI #_____DEA#_____

Physician Address:_____ Phone #_____ Fax #_____

Fax To 747-900-8489

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