

# ENDOCRINOLOGY REFERRAL FORM

## PATIENT INFORMATION

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

Last Name	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	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/cm<sup>2</sup>): \_\_\_\_\_ T-Score: \_\_\_\_\_ Date: \_\_\_\_\_
- DXA Results (g/cm<sup>2</sup>): \_\_\_\_\_ T-Score: \_\_\_\_\_ Date: \_\_\_\_\_

**Prior Failed Medications:**

**Duration/Reason of Discontinuation**


## PRESCRIPTION INFORMATION

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

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Office contact: \_\_\_\_\_

Physician Name: \_\_\_\_\_ UPIN # \_\_\_\_\_ NPI # \_\_\_\_\_ DEA# \_\_\_\_\_

Physician Address: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

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