PUBLIX PHARMACY

Feeling well. Living better.

Osteoporosis Referral Form

Publix Specialty Pharmacy (#3212)

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Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ___________________________ Patient's Last Name: ____________________________ Date of Birth: ___/___/_____ ☐ Male ☐ Female

Address: ____ City: ____________________________ State: ___________ Zip: __________________

Primary Phone Number: (_____) ________________ Alt. Phone Number: (_____) _____________________ Caregiver name: ____________________________

Clinical Information [Attach copy of labs and office notes]

Diagnosis code: ________________ Diagnosis: ☐ Postmenopausal osteoporosis ☐ Primary/Hypogonadal osteoporosis ☐ Glucocorticoid-induced osteoporosis

Treatment status: ☐ New to therapy ☐ Continuation of therapy, start date: ___/___/______ Weight: _______ ☐ kg ☐ lb Height: _______ ☐ cm ☐ in

BMD/T-score: ________ Date of T-score: ___/___/_____ Fracture history: ☐ None ☐ Site(s) and date(s): ____

Serum Creatinine: ________ mg/dL, CrCl: ________ mL/min, Serum Calcium: ________ mg/dL, Serum Albumin: ________ g/dL, Date of labs: ___/___/______

Supplements: ☐ Calcium, dose: ____________________ ☐ Vitamin D, dose: _______________________ ☐ Neither, reason: ____________________________

Oral bisphosphonates: ☐ Never tried ☐ Contraindicated/failed, describe: ____

IV bisphosphonates: ☐ Never tried ☐ Contraindicated/failed, describe: ____

Other pertinent past medical history and/or drug therapy: ____

____

Allergies: ☐ NKDA ☐ Other: ____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY FOR	REFILLS
☐ Boniva (ibandronate)	3 mg/3 mL prefilled syringe	Inject 3 mg IV over 15-30 seconds every 3 months (to be administered by healthcare professional)	90 days	________
☐ Forteo (teriparatide) Include: ☐ 8mm x 31G pen needles ☐ 4mm x 32G pen needles	600 mcg/2.4 mL prefilled pen	Inject 20 mcg SC once a day (discard device 28 days after first use)	☐ 28 days ☐ 84 days	________
☐ Prolia (denosumab)	60 mg/mL prefilled syringe	Inject 60 mg SC every 6 months (to be administered by healthcare professional)	180 days	________
☐ Reclast (zoledronic acid)	5 mg/100 mL bottle	Infuse 5 mg IV over no less than 15 minutes once a year (to be administered by healthcare professional)	1 year	________
☐ Tymlos (abaloparatide) Include: ☐ 8mm x 31G pen needles	3120 mcg/1.56 mL prefilled pen	Inject 80 mcg SC once a day (discard device 30 days after first use)	☐ 30 days ☐ 90 days	________
☐ Other: ________________________	________________	____	__________________	________

Prescriber Information [Ship to prescriber: ☐ Never ☐ Always ☐ First fill only, appointment date: ___/___/_____] Use Cover My Meds: ☐ Yes ☐ No

Name: ____ DEA# _________________________ NPI # _______________________________________

Address: ____ City: ___________________________ State: ___________ Zip: __________________

Office Phone Number: (_____) _________________ Fax Number: (_____) _______________________ Office Contact: ______________________________

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: (stamps not accepted) ______________________________________ ☐ Substitution allowed Date ______________________________________ ☐ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

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