Osteoporosis Referral Form

Please fax completed referral form to ivira:
(302) 499-8729
Please contact office for questions:
(302) 499-8727

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	SECONDARY CONTACT #:
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH: GENDER: ☐ F ☐ M	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ M81.0 - Generalized Osteoporosis ☐ M81.0 - Postmenopausal Osteoporosis ☐ M81.8 - Idiopathic Osteoporosis
☐ M81.8 - NEC Osteoporosis ☐ Other:______________________________

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. PATIENT DEMOGRAPHICS ☐ 3. MOST RECECNT LABS ☐ 4. H & P

MEDICATION SELECTION:

Medication	Directions	Refills
Boniva (ibandronate sodium)	☐ INJECT 3MG IV PUSH EVERY 3 MONTHS	REFILLS:______
EVENITY (romosozumab-aqqg) injection 105 mg/1.17 mL	☐ INJECT 210 MG ONCE MONTHLY FOR 12 MONTHS	REFILLS: NR
Reclast (zoledronic acid)	☐ INFUSE 5 MG IV OVER 15-20 MINUTES ANNUALLY	REFILLS:______
FORTÉO™ teriparatide (rDNA origin) injection	☐ INJECT 20 MCG SC, AS DIRECTED, DAILY	REFILLS:______
prolia denosumab	☐ INJECT 60 MG SC ONCE EVERY 6 MONTHS	REFILLS:______
TYMLOS (abaloparatide) injection	☐ INJECT 80 MG SC ONCE DAILY IN PERIUMBILICAL REGION	REFILLS:______
PEN NEEDLES	☐ 30 GAUGE ☐ 31 GAUGE ☐ 32 GAUGE	

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

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PHYSICIAN SIGNATURE: DATE:

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby vauthorize Ivira Health and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.