ST.JUDE
SPECIALTY PHARMACY
& MEDICAL SUPPLIES

OSTEOPOROSIS PRESCRIPTION REFERRAL FORM

121 St. Nicholas Ave Brooklyn, NY 11237
TEL: 718-381-5116 FAX: 718-417-3621
Proudly serving over 30 years

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name First Name ______ Middle Name ______ Last Name ______ DOB ______ Weight ______ ☐ Male ☐ Female
Street Address ______ Apt # ______ City ______ State ______ Zip ______
Daytime Tel ______ Evening Tel ______ Cell ______ Email ______
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed ______
ICD-9 Diagnosis Code ______ Allergies ______ BSA ______ m^2
Patient currently on therapy ☐ Yes ☐ No Date of diagnosis ______ **INSURANCE INFORMATION** Please fax copy of insurance card (front & back)

Prescriber's Name ______ Office Contact ______
Street Address ______ Suite # ______ City ______ State ______ Zip ______
Tel ______ Fax ______ Email ______
License# ______ NPI# ______ UPIN# ______ DEA# ______

Clinical Information

☐ Yes ☐ No Is the patient unable to remain in an upright position during post oral bisphosphonate administration?
☐ Yes ☐ No Does the patient have documented treatment failure after an adequate trialof at least two oral bisphosphonates?
If yes, please check all that apply: ☐ Fosamax or Fosamax plus D (alendronate) ☐ Didronel (elidronate) ☐ Skelid (tiludronate)
☐ Actonel or Actonel with Calcium or Atelvia (risedronale) ☐ Oral Bonlva (ibandronate) ☐ Other ______
☐ Yes ☐ No Does the patient have documented treatment failure after an adequate trialof at least one oral bisphosphonate and one SERM?
If yes, please check all that apply: ☐ Fosamax or Fosamax plus D (alendronate) ☐ Didronel (elidronate) ☐ Skelid (tiludronate)
☐ Actonel or Actonel with Calcium or Atelvia (risedronale) ☐ Oral Boniva (ibandronate) ☐ Other ______
☐ Tamoxifen (nolvadex) ☐ Evista (raloxifene) ☐ Femara (letrozole) ☐ Fareston (toremlfene)
☐ Yes ☐ No Does the patient have a documented medical reason (intolerance, hypersensitivity,and/or contraindication) to avoid using oral bisphosphonates or SERMS?
☐ Yes ☐ No Does the patient have Dysphagia (difficulty swallowing)?
Please check or list all indications that apply to this patient: **If any of these are checked, please refer to the product package insert for appropriate indications, warnings, and contraindications.**
☐ Presence or history of osteoporotic vertebral compression fracture and/or hip fracture
☐ Currently taking calcium and Vitamin D ☐ BMD greater than -2.5 ☐ BMD -1.0 and -2.5 ☐ Other ______

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **Boniva** ☐ **Prolia** ☐ **Other** ______
☐ **Forteo** ☐ **Reclast** ☐ **Other** ______

Dosage ______
SIG ______
QTY ______ **Refills** ______

Prescriber's Signature (signature required. NO STAMPS) ______ **Date** ______

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. 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 in error and then destroy this document immediately. PLEASE NOTE: St. JUDE can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

Please fax completed form to St. Jude at **718-417-3621** Visit us at **www.stjuderx.com** for online fillable forms.