PROLIA®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: ________________________________ DOB: ____________

Address: ____

City, State, Zip: ____

Phone: ___________________ Alt. Phone: ________________

Email: _________________________ SS#: _________________

Gender: ☐ M ☐ F Weight: _______(lbs) Ht: ______________

Allergies: ____

PRESCRIBER INFORMATION

Prescriber Name: ____________________________________

State License: ______________________________________

NPI #: ________________ DEA: ___________________________

Address: ____

City, State, Zip: ______________________________________

Phone: ____________________ Fax: ______________________

Office Contact: ______________________ Phone: ______________

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: ____

Plan #: ____

Group #: ____

RX Card (PBM): ____

BIN: _____________________ PCN: _______________________

Secondary Insurance (If Applicable): ___________________________

Plan #: ____

Group #: ____

RX Card (PBM): ____

BIN: _____________________ PCN: _______________________

CLINICAL INFORMATION

☐ M81.8 Osteoporosis, unspecified ☐ M81.00 Osteoporosis without pathological fracture ☐ Other (specify ICD-10):____________________

T-Score (If known): ____

History of osteoporotic fracture? ☐ Yes ☐ No Skeletal Site (If known): __________________________________

Has the patient failed or is unable to tolerate bisphosphonate therapy? ☐Yes ☐ No

↳ If yes, please explain: ____

Does the patient have >1 risk factor for fracture? ☐ Yes ☐ No

↳ If yes, please explain: ____

Reason for discontinuing previous osteoporosis therapies: ______________________________________

PROLIA® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: __________ Date of Last Infusion/Injection: __________

Medication	Directions	Quantity/Refills
☐ Prolia® 60mg prefilled syringe	Inject 60mg subcutaneously every 6 months	Quantity: _______________ Refills: _______________

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X____ Date: ________________

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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