



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____	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: _____ City, State, Zip: _____ Plan #: _____ Group #: _____ Phone: _____	RX Card (PBM): _____ BIN: _____ PCN: _____ City, State, Zip: _____ Group #: _____ Phone: _____		
Secondary Insurance (If Applicable):			
Secondary Insurance: _____ Plan #: _____ Phone: _____	City, State, Zip: _____ Group #: _____		
CLINICAL INFORMATION			
<input type="checkbox"/> M81.8 Osteoporosis, unspecified <input type="checkbox"/> M81.00 Osteoporosis without pathological fracture <input type="checkbox"/> Other (specify ICD-10): _____			
T-Score (If known): _____			
History of osteoporotic fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No Skeletal Site (If known): _____			
Has the patient failed or is unable to tolerate bisphosphonate therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input checked="" type="checkbox"/> If yes, please explain: _____			
Does the patient have >1 risk factor for fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input checked="" type="checkbox"/> If yes, please explain: _____			
Reason for discontinuing previous osteoporosis therapies: _____			
IBANDRONATE SODIUM ORDERS			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Infusion/Injection: _____			
Medication	Dose/Frequency	Refills	
<input type="checkbox"/> Ibandronate Sodium (Boniva Generic)	<input type="checkbox"/> Infuse 3mg IV once a year <input type="checkbox"/> Other: _____	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 _____ <div style="text-align: center;">Prescriber Signature</div>		Date: _____	

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.

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.