BONE AND JOINT HEALTH REFERRAL FORM

Albertsons Companies Specialty Care | MEDCART SPECIALTY PHARMACY | Jewel Osco | Albertsons | SAFEWAY | VONS | ACME | shaw's | star market | PAVILIONS | CARRS | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

_____

Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Euflexxa (sodium hyaluronate)	20mg/2mL Prefilled Syringe	Inject 20mg (2mL) intra-articularly into the knee once weekly for 3 weeks.	☐ 6mL ☐ 1 syringe	
☐ Forteo (teriparatide) ☐ WITH Pen Needles	☐ 600mcg/2.4mL Pen ☐ 32 gauge 4mm	☐ Inject 20mcg subcutaneously every day. ☐ Use with Forteo daily.	☐ 1 pen ☐ 30 pen needles	
☐ Prolia (denosumab)	60mg/mL Prefilled Syringe	Inject 60mg subcutaneously every 6 months.	1 syringe	
☐ Tymlos (abaloparatide)	3120mcg/1.56mL Pen-injector	Inject 80mcg subcutaneously once daily.	1 pen	
☐ Xgeva (denosumab)	☐ 120mg/1.7mL	☐ Administer 120mg subcutaneously every 4 weeks. ☐ Administer additional 120mg doses subcutaneously on days 8 and 15 of the first month of therapy.	☐ 1 vials ☐ 3 vials	
Other Medication Name:				

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____

Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy ☐ Pharmacist may administer

Date Medication Needed: _____