

Osteoporosis

2301 Evesham Road - Building 800, Suite 115
Voorhees, New Jersey 08043
T. (856) 424-5005 ext 1181
F.(609)751-9799 attn: Idyllic Infusion Coordinator

MEDICATION REQUESTED

DATE:

NAME OF DRUG BEING REQUESTED:

Please circle one: Boniva, Evenity, Prolia, Reclast
(IDYLLIC will be responsible for providing requested drug)

REFERRING PROVIDER INFORMATION

Requesting Provider	Name: NPI: Tax ID#	
Phone Number		
Fax Number		
Practice Contact (Name/Extension)	Phone Number:	Ext:
Contact Email		

We will gladly remind your patient to schedule routine follow-up visits with your office.

Return to Referring Provider (frequency): EVERY _____ WKS / MOS

PATIENT INFORMATION

Patient Name		
Insurance(s) Include copy of scanned card(s)		
Date of Birth	/	/
Select Treatment Location	☐ Voorhees ☐ Moorestown ☐ Wall/Manasquan ☐ Sewell ☐ Hamilton ☐ Galloway	

● Patient is being referred to Idyllic/ ARBDA provider for treatment of Osteoporosis. This includes treatment plan, medication management, monitoring and/or ordering of all labs and imaging.

● Patient is being referred to ARBDA/Idyllic for administration of requested medications only. The ordering provider, listed above, will be in charge of the treatment plan including medication management, monitoring and/ordering of all labs and imaging.

PLEASE BE SURE TO SEND ALL REQUIRED INFORMATION LISTED BELOW

Patient's Name (Last, First) _____

DOCUMENTATION REQUIRED:

- ☐ Primary Diagnosis code.
 - ☐ M80.0 Age-related Osteoporosis w/ fx at _____
 - ☐ M80.0 requires the complete ICD-10 code with 3 digits and a letter after the decimal
 - ☐ M81.0 Age-related osteoporosis w/o fx _____
 - ☐ M81.8 Other osteoporosis w/o fx _____
 - ☐ Other _____
- ☐ Please attach a prescription to include standard information as well as any specific instructions
 - ** NOTE ** Please do **NOT** provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- ☐ Copy of the most recent chart note, scans, tests and laboratory results.
- ☐ If female, does the patient have a BMD T-score ≤ -2.5 ? ____
- ☐ Osteopenia with T-score between -1 and 02.5 ? ____
- ☐ Has the patient had a low-trauma spine or hip fracture? ____
- ☐ Has a patient failed a trial on, or is intolerant to, bisphosphonate and/or other osteoporosis therapy? ____
- ☐ Is the patient at high risk for fracture? ____ If yes, provide supporting documentation.
- ☐ Please provide most recent calcium levels
- ☐ Is the patient planning to concomitantly take parathyroid hormone analogs, RANK ligand inhibitors, or bisphosphonates? ____
- ☐ Will the patient be taking a daily supplement of at least 1000 mg calcium and at least 400 IU Vitamin D? ____
- ☐ Please list any premedications required _____
- ☐ Is this patient ambulatory YES / NO
 - ☐ Is a Wheelchair required YES / NO

- ☐ Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.

PLEASE NOTE: OUR OFFICE PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS
ARBDA/IDYLLIC NPI: 1427622661 TAX ID: 85-1604336