TENNESSEE ONCOLOGY

a partner of OneOncology

Prolia/Reclast/Evenity Referral Form

Patient Name: _____ **Date of Birth:** _____ **Weight:** _____

Patient Phone: _____ **Date of Referral:** _____

Referring Provider: _____ **MD Phone:** _____ **MD Fax:** _____

Preferred Clinic Location: _____ **Preferred Provider:** _____

Records Required for Referral:

1. **Attach** most recent **DEXA** scan results **(must be within the last 2 years)** Date of Scan: _____ **T-Score:** _____
2. **Attach** most recent **CMP/BMP(must be within 46 weeks of referral).** Date of Labs: _____ **Note: *Ref Range for Serum Ca: 8.6 - 10.2mg/dl*** **Serum Ca:** _____
3. **Attach** most recent **office note**. Date of Office Visit: _____

Diagnosis: Please check the appropriate diagnosis listed below, and complete ALL required fields:

PROLIA	RECLAST	EVENITY
☐ Treatment of Postmenopausal women with osteoporosis at high risk for fracture ☐ Treatment to increase bone mass in men with osteoporosis at high risk for fracture. ☐ Treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer. ☐ Treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer.	☐ Treatment and prevention of postmenopausal osteoporosis ☐ Treatment to increase bone mass in men with osteoporosis ☐ Treatment and prevention of glucocorticoid induced osteoporosis ☐ Treatment of Paget's Disease of bone in men and women **Serum Creatinine:** _____ **Creatinine Clearance:** _____ **Note: *CrCl must be >35ml/min***	☐ Treatment of osteoporosis in postmenopausal women at high risk of fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture, or patients who failed or are intolerant of other available therapy.

If no preferred medication is chosen, TN Oncology will default to the medication preferred by the patient's insurance.

Previous Treatment		
Any previous oral/IV bisphosphonate treatment? ☐ **YES** ☐ **NO**		
Reason for Failure : (circle) **Intolerant/ GI/PPI Failure / Other:** _____	**Agent Name:** _____ **PO /IV**	**Is this continuation of care?** ☐ **YES** ☐ **NO**
Fracture History		
Does the patient have a history of osteoporotic fracture? ☐ **YES** ☐ **NO**	**Date:** _____ **Fracture site:** _____	***Radiology reports of previous osteoporotic fracture(s) are required for referral. (X -Ray/MRI/CT)***

***** I understand that any missing records required for referral could delay processing of this referral. *****

Completed by : _____ **Date:** _____

www.tnoncology.com/therapies

FAX TO: 615 -986-4381