



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ DEA: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

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
↳ If yes, please explain: _____
Does the patient have >1 risk factor for fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No
↳ If yes, please explain: _____
Reason for discontinuing previous osteoporosis therapies: _____

PROLIA® 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	Directions	Quantity/Refills
<input type="checkbox"/> 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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