IBANDRONATE SODIUM (Boniva® Generic)

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: ______________________ DOB: __________
Address: ______________________
City, State, Zip: ______________________
Phone: ______________ Alt. Phone: ______________
Email: ______________ SS#: ______________
Gender: ☐ M ☐ F Weight: ______(lbs) Ht: __________
Allergies: ______________________

PRESCRIBER INFORMATION

Prescriber Name: ______________________
State License: ______________________
NPI #: __________ DEA: ______________
Address: ______________________
City, State, Zip: ______________________
Phone: ______________ Fax: ______________
Office Contact: ______________ Phone: __________

INSURANCE INFORMATION – OR – 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: ______________________ City, State, Zip: ______________________
Plan #: ______________________ Group #: ______________________
Phone: ______________________

CLINICAL INFORMATION

☐ M81.8 Osteoporosis, unspecified ☐ M81.00 Osteoporosis without pathological fracture ☐ Other (specify ICD-10):______________
T-Score (If known): ______________________
History of osteoporotic fracture? ☐ Yes ☐ No Skeletal Site (If known): ______________________
Has the patient failed or is unable to tolerate bisphosphonate therapy? ☐Yes ☐ No
If yes, please explain: ______________________
Does the patient have >1 risk factor for fracture? ☐ Yes ☐ No
If yes, please explain: ______________________
Reason for discontinuing previous osteoporosis therapies: ______________________

IBANDRONATE SODIUM ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: ________ Date of Last Infusion/Injection: ________

Medication	Dose/Frequency	Refills
☐ Ibandronate Sodium (Boniva Generic)	☐ Infuse 3mg IV once a year ☐ 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______________________________ 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.

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.