

Osteoporosis

Patient Information – Please attach a copy of the patient’s insurance card

Patient Name:		Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		City:	State: Zip:
Phone Number:	Alternate Phone Number:		Language:
Allergies (Required): <input type="checkbox"/> NKDA		Height:	Weight: SSN:
Product Shipping Options: <input type="checkbox"/> Patient’s Home <input type="checkbox"/> Prescriber Office <input type="checkbox"/> Alternative Address:			

Insurance: Please fax copy of insurance card (front and back)

Prescriber Information

Practice Name:		Office Contact:	
Prescriber:		NPI:	DEA:
Practice Address:		City:	State: Zip:
Phone Number:		Fax Number:	

Clinical Notes: Please send last 3 available chart notes and lab results with order

Clinical Information

Diagnosis/ICD-10:		
BMD/T-score: Date of score:	Is the patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of osteoporotic fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is the patient at high risk? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of fracture: Location of fracture:
Prior Failed Medications: <input type="checkbox"/> Actonel® <input type="checkbox"/> Boniva® <input type="checkbox"/> Forteo® <input type="checkbox"/> Fosamax® <input type="checkbox"/> Prolia® <input type="checkbox"/> Reclast® <input type="checkbox"/> Other:		

Prescription Information

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Forteo®	600 mcg/2.4 mL pen	Inject 1 dose (20 mcg) subcutaneously once daily. Discard device 28 days after first use. Dispensed with BD Mini™ Pen Needles (28 needles per 1 pen dispensed)	1 pen	
<input type="checkbox"/> Prolia®	60 mg/1 mL prefilled syringe	Inject the contents of 1 syringe (60 mg) subcutaneously every 6 months	1 prefilled syringe	
<input type="checkbox"/> Tymlos™	3120 mcg/1.56 mL pen	Inject 1 dose (80 mcg) subcutaneously once daily. Discard device 30 days after first use. Dispensed with BD Short™ Pen Needles (30 needles per 1 pen dispensed)	1 pen	
<input type="checkbox"/> Other:				

Prescriber Signature and Date (Please sign and date below)

_____	_____	_____	_____
Dispense as Written	Date	Substitution Permissible	Date
<input type="checkbox"/> Check here to authorize the receiving pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber’s behalf. “I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge”			

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