Osteoporosis Enrollment Form

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐Male ☐Female
Email Address: _____
Last 4 digits SS#: _____

PRESCRIBER INFORMATION

Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION

If available, please fax copy of prescription insurance cards with this form (front and back).

PRESCRIPTION

DIAGNOSIS:

☐ M81.0 Age-related osteoporosis without current pathological fracture
☐ M81.8 Other osteoporosis without current pathological fracture
☐ Z79.51 Long term (current) use of inhaled steroids
☐ Z79.52 Long term (current) use of systemic steroids
☐ Other: _____

Prior (FAILED) Therapy:

Therapy	Date(s)
☐ **Fosamax**	_____
☐ **Actonel**	_____
☐ **Boniva**	_____
☐ **Prolia**	_____
☐ **Reclast**	_____
☐ **Forteo**	_____
☐ **Other (please list):**	_____

Date of Diagnosis: _____ BMD/T-Score: _____ Is patient new to therapy? ☐Yes ☐No

History of osteoporotic fracture? Yes No
If yes, date of fracture: _____ Location of fracture: _____
If no, is patient at high risk? ☐Yes ☐No

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ Forteo®	☐ 600 mcg/2.4 mL Pen	☐ Inject 1 dose (20 mcg) subcutaneously once daily. Discard device 28 days after first use.	☐ 1 pen *(4-week supply)* ☐ 3 pens *(12-week supply)*	_____
☐ BD® Mini Pen Needles	☐ 31G x 3/16"	☐ Use with Forteo® pen once daily as directed	☐ #100 Pen Needles ☐ #30 Pen Needles	_____
☐ Prolia®	☐ 60 mg/1 mL PFS	☐ Inject the contents of 1 syringe (60 mg) subcutaneously every 6 months	1 Prefilled Syringe	_____
☐ Reclast®	☐ 5 mg/100 mL vial	☐ Infuse 5 mg intravenously over no less than 15 minutes once annually	One: 5 mg/100 mL vial	___0___
☐ Boniva®	☐ 3 mg/3 mL PFS	☐ Inject the contents of 1 syringe (3 mg) intravenously every 3 months. To be administered by a healthcare professional.	One: 3 mg/3 mL PFS	_____

PHYSICIAN SIGNATURE

To Physician: By signing this form and utilizing our services, you are also authorizing pharmacy to serve as your prior authorization agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Physician Signature: _____ **Date**: _____

CONFIDENTIALITY NOTICE

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