# Osteoporosis

**Phone: (877) 883-1392 Fax: (256) 429-2221**

**Patient Information:** Name: _____ DOB: _____ Gender: ◯ M ◯ F

Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____ Email: _____
Height: _____ Weight: _____ Last 4 of SSN: _____ Caregiver: _____ Allergies: ◯ No Known ◯ See Charts
◯ Other: _____

**Please include front and back copies of insurance card – including pharmacy coverage**

**Prescriber Information:**

Name: _____ NPI: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____
Office Contact: _____

**Statement of Medical Necessity (Please attach all chart information):**

Date of Diagnosis: _____ ICD-10: _____ Other: _____
Is patient new to therapy? ◯ Yes ◯ No
Continuing therapy? ◯ Yes ◯ No

- Date therapy started: _____
- Date of last injection: _____

Is patient at high risk for fracture? ◯ Yes ◯ No
History of osteoporotic fracture? ◯ Yes ◯ No

- If yes, location of fracture: _____
- Date of fracture: _____

BMD/T-Score: _____ Date: _____
FRAX Score: _____ Date: _____
Contraindication(s) to bisphosphonate therapy? ◯ Yes ◯ No

- If yes: ◯ Dysphagia ◯ GERD ◯ Ulcer ◯ Other: _____

Is patient currently taking calcium and vitamin D supplements? ◯ Yes ◯ No
Has patient had a myocardial infarction or stroke within the previous year?
◯ Yes ◯ No
Labs: Calcium: _____ Vitamin D: _____ Date: _____

| Prior Failed Treatments | Length of Treatment |
|---|---|
| ◯ Actonel | |
| ◯ Boniva | |
| ◯ Forteo | |
| ◯ Fosamax | |
| ◯ Prolia | |
| ◯ Reclast | |
| ◯ Other: | |

**Please attach all medical documentation including: DEXA scan, medical history, CMP panel, other information pertinent to the case**

**Injection Training:** ◯ Pharmacist to Provide Training ◯ Patient Trained in MD Office ◯ Manufacturer Nurse Support
**Product Delivery:** ◯ Patient's Home ◯ Physician's Office ◯ Pharmacy to Coordinate

**Prescription Information:**

| Medication | Dosage | Directions | Qty. | Refills |
|---|---|---|---|---|
| ◯ Evenity | ◯ 105 mg/1.17 mL Prefilled Syringe | ◯ Inject 210 mg SubQ (two 105 mg injections, one after the other) by a healthcare provider every month for 12 months | 2 | 11 |
| ◯ Forteo | ◯ 600 mcg/2.4 mL Pen | ◯ Inject 20 mcg SubQ daily | 1 | |
| ◯ Pen Needles | ◯ 31 Gauge ◯ 5 mm | | 100 | |
| ◯ Prolia | ◯ 60 mg/mL Prefilled Syringe | ◯ Inject 60 mg SubQ every 6 months | 1 | |

**Prescriber's Signature** (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: _____ Signature: _____ Date: _____

**Substitution Permitted** **Dispense as Written**

**Note: Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.**



**Revised 09/28/2022**