



Patient Information: Name: _____ DOB: _____ Gender: M F
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____ Email: _____ Ht: _____ Wt: _____
 Care Giver: _____ Allergies: No Known See Attached Charts Other: _____

Please include front and back copies of insurance card

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

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____ Is patient new to therapy? Yes No Continuing therapy? Yes No
 Date therapy started: _____ Date of last injection: _____ Is patient high risk for fracture? Yes No
 History of osteoporotic fracture? No Yes 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 myocardia infarction or stroke within the preceding year? Yes No
 Please attach all medical documentation including: DEXA Scan Medication History OCM Panel Other Information Pertinent to the Case
 Labs: Calcium: _____ Vitamin D: _____ Date: _____

Injection Training: Pharmacist to Provide Training
 Patient Trained in MD Office
 Manufacturer Nurse Support

Prior Failed Therapies	Length of Treatment
<input type="radio"/> Actonel	
<input type="radio"/> Boniva	
<input type="radio"/> Forteo	
<input type="radio"/> Fosamax	
<input type="radio"/> Prolia	
<input type="radio"/> Reclast	
<input type="radio"/> Other	

Product Delivery: Patient's Home
 Physician's Office
 Pharmacy to Coordinate

Prescription Information:

Medication	Dosage	Directions	Qty	Refills
<input type="radio"/> Evenity	<input type="radio"/> 105mg/1.17ml Prefilled Syringe	<input type="radio"/> Inject 210mg SC (two 105mg injections, one after the other,) by a healthcare provider, every month for 12 months in the abdomen, thigh, or upper arm	2	
<input type="radio"/> Forteo <input type="radio"/> Pen Needles	<input type="radio"/> 600mcg/2.4ml Pen <input type="radio"/> 31 Gauge <input type="radio"/> 5mm	<input type="radio"/> Inject 20mcg subcutaneously daily	1 100	
<input type="radio"/> Prolia	<input type="radio"/> 60mg/ml Prefilled Syringe	<input type="radio"/> Inject 60mg subcutaneously every 6 months	1	
<input type="radio"/> Tymlos <input type="radio"/> Pen Needles	<input type="radio"/> 3,120mcg/1.56ml Prefilled Pen <input type="radio"/> 31 Gauge <input type="radio"/> 8mm <input type="radio"/> 5mm	<input type="radio"/> Inject 80mcg subcutaneously daily into the periumbilical region of the abdomen	1 100	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

Prescriber 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**
 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.

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