Osteoporosis

Call: (877) 883-1392 Fax: (256) 429-2221

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: _____

Last 4 of SSN:

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 ○CMP 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

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

Prior Failed Therapies	Length of Treatment
○ Actonel	
○ Boniva	
○ Forteo	
○ Fosamax	
○ Prolia	
○ Reclast	
○ Other	

Prescription Information:

Medication	Dosage	Directions	Qty	Refills
○Evenity	○ 105mg/1.17ml Prefilled Syringe	○ 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	
○Forteo	○ 600mcg/2.4ml Pen	○ Inject 20mcg subcutaneously daily	1	
○Pen Needles	○ 31 Gauge ○ 5mm		100	
○Prolia	○ 60mg/ml Prefilled Syringe	○ Inject 60mg subcutaneously every 6 months	1	
○Tymlos	○ 3,120mcg/1.56ml Prefilled Pen	○ Inject 80mcg subcutaneously daily into the periumbilical region of the abdomen	1	
○Pen Needles	○ 31 Gauge ○ 8mm ○ 5mm		100	
☐	○	○		

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.

Revised 10/15/2020