Osteoporosis Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

OPRX-20-01

CLINICAL CONSIDERATIONS

Diagnosis Date: _____ / _____ / _____
Diagnosis:
☐ M80.0 Age related osteoporosis with current pathological fracture
☐ M81.0 Age related osteoporosis without current pathological fracture
☐ M80.8 Other osteoporosis with current pathological fracture
☐ M81.8 Other osteoporosis without current pathological fracture
☐ Other: _____

Is patient new to therapy?: ☐ Yes ☐ No
History of osteoporotic fracture? ☐ Yes ☐ No ☐ Not Known
If yes, date of fracture: _____ / _____ / _____
Please specify fracture site: _____

T-Score: _____ Date: _____ / _____ / _____

Please list previously tried/failed therapies & dates:
☐ Fosamax® (alendronate) Date: _____ / _____ / _____
☐ Boniva® (ibandronate) Date: _____ / _____ / _____
☐ Actonel® (risendronate) Date: _____ / _____ / _____
☐ Other: Date: _____ / _____ / _____

Reason for Discontinuing Previous Therapy:

Contraindications (if any):

Is patient currently receiving calcium and vitamin D supplements?: ☐ Yes ☐ No

Immunization History
☐ Influenza
Date: _____ / _____ / _____

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Forteo®** (teriparatide)	☐ 600 mcg / 2.4 mL pen	☐ Inject 20 mcg (0.08 mL) subcutaneously once daily	1 pen (4-week supply)	
	☐ Pen Needles 31G X 5 mm ☐ Pen Needles 31G X 8 mm	☐ Use with Forteo as directed		
☐ **Prolia®** (denosumab)	☐ 60 mg prefilled syringe	☐ Inject 60 mg subcutaneously every 6 months	1 prefilled syringe	
☐ **Tymlos®** (abaloparatide)	☐ 3120 mcg/1.56 mL pen	☐ Inject 80 mcg (0.04 mL) subcutaneously once daily	1 pen (30 day supply)	
	☐ Pen Needles 31G X 5 mm ☐ Pen Needles 31G X 8 mm	☐ Use with Tymlos as directed		

Injection Training
Injection training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____
NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ / ____ / ____