



# OSTEOPOROSIS SPECIALTY CARE PROGRAM

Phone: **844-283-6308** • Fax: **844-965-9849**



## 1 PATIENT INFORMATION:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Gender:  M  F Caregiver: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

## 2 PRESCRIBER INFORMATION:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
 Tax I.D.: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

## 3 STATEMENT OF MEDICAL NECESSITY:

Date of Diagnosis: \_\_\_\_\_ Is patient new to therapy?  Yes  No  
 ICD-10: \_\_\_\_\_ Is patient high risk for fracture?  Yes  No  
 Other: \_\_\_\_\_ History of osteoporotic fracture?  Yes  No  
 BMD/T-Score: \_\_\_\_\_ Date: \_\_\_\_\_ FRAX Score: \_\_\_\_\_ Date: \_\_\_\_\_  
 If Yes, Location of Fracture: \_\_\_\_\_ Date of Fracture: \_\_\_\_\_  
 Contraindication(s) to bisphosphonate therapy?  No  Yes  
 If Yes:  Dysphagia  GERD  Ulcer  Other \_\_\_\_\_

Prior Failed Treatments:	Length of Treatment:
<input type="checkbox"/> Actonel®	_____
<input type="checkbox"/> Boniva®	_____
<input type="checkbox"/> Forteo®	_____
<input type="checkbox"/> Fosamax®	_____
<input type="checkbox"/> Prolia®	_____
<input type="checkbox"/> Reclast®	_____
<input type="checkbox"/> Other	_____

### Please Attach All Medical Documentation Including:

DEXA Scan  Medication History  CMP Panel  Other Information Pertinent to the Case  
 Labs: Calcium: \_\_\_\_\_ Vitamin D: \_\_\_\_\_ Date: \_\_\_\_\_

**If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.**

## 4 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

## 5 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

## 6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

### PRESCRIPTION INFORMATION:

Patient Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> FORTEO®	<input type="checkbox"/> 600mcg/2.4ml Pen	<input type="checkbox"/> Inject 20mcg SC once daily	1	
<input type="checkbox"/> PEN NEEDLES	<input type="checkbox"/> 31 Gauge <input type="checkbox"/> 5mm		100	
<input type="checkbox"/> PROLIA®	<input type="checkbox"/> 60mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 60mg SC every 6 months	1	
<input type="checkbox"/> TYMLOS™	<input type="checkbox"/> 3,120mcg/1.56ml Prefilled Pen	<input type="checkbox"/> Inject 80mcg subcutaneously once daily into the periumbilical region of the abdomen	1	
<input type="checkbox"/> PEN NEEDLES	<input type="checkbox"/> 31 Gauge <input type="checkbox"/> 8mm		100	
<input type="checkbox"/> _____	_____	_____		

**PRESCRIBER SIGNATURE:** I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ 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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