



OSTEOPOROSIS SPECIALTY CARE PROGRAM

Phone: **888-216-1949** • Fax: **888-977-1391**



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 _____

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: Automatically Draft Appeal for Review Send Formulary Preferred Alternatives

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	_____

4 PRESCRIPTION INFORMATION:

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> BONIVA®	<input type="checkbox"/> 3mg/3ml Prefilled Syringe	<input type="checkbox"/> Inject 3mg IV every 3 months	1	
<input type="checkbox"/> FORTEO®	<input type="checkbox"/> 600mcg/2.4ml Pen	<input type="checkbox"/> Inject 20mcg SC once daily	1	
<input type="checkbox"/> PROLIA®	<input type="checkbox"/> 60mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 60mg SC every 6 months	1	
<input type="checkbox"/> PEN NEEDLES	<input type="checkbox"/> 31 Gauge <input type="checkbox"/> 4mm <input type="checkbox"/> 5mm <input type="checkbox"/> 6mm			
<input type="checkbox"/> _____	_____	_____		

5 INJECTION TRAINING: To Be Administered by Pharmacist Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

6 PICK UP OR DELIVERY: Delivery to Patient's Home Delivery to Physician's Office Pharmacy to Coordinate

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

8 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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