



OSTEOPOROSIS SPECIALTY CARE PROGRAM

Phone: **856-963-4742** • Fax: **856-541-8580**



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: _____ ICD-10: _____
 Is patient new to therapy? Yes No Is patient continuing therapy? Yes No
 Date therapy started: _____ Date of last injection: _____
 Is patient high risk for fracture? Yes No History of osteoporotic fracture? Yes No
 If Yes, Location of Fracture: _____ Date of Fracture: _____
 BMD/T-Score: _____ Date: _____ FRAX Score: _____ Date: _____
 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: _____
 Is patient currently taking Calcium and Vitamin D supplements? Yes No
 Has patient had a myocardial infarction or stroke within the preceding year? Yes No

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

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 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"/> EVENITY™	<input type="checkbox"/> 105mg/1.17ml Prefilled Syringe	<input type="checkbox"/> 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="checkbox"/> FORTEO®	<input type="checkbox"/> 600mcg/2.4ml Pen	<input type="checkbox"/> Inject 20mcg subcutaneously 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 subcutaneously 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 <input type="checkbox"/> 5mm		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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