

# Osteoporosis

## Prescription & Pharmacy Intake Form



**Phone: 1-718-762-7400**  
**Fax: 1-718-762-7404**  
**Toll Free: 1-888-93-EVERS**

Provider Representative | Phone \_\_\_\_\_ Date Needed \_\_\_\_\_ Ship to  Specialty Care Center  Patient's Home  
 Prescriber's Office  Other \_\_\_\_\_

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone # (Daytime): \_\_\_\_\_ Phone # (Evening): \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_  
 Insurance Provider (Please include copy of front and back of card): \_\_\_\_\_  
 ID #: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Relationship to Patient:  Self  Other: \_\_\_\_\_  Patient is Eligible for Medicare  
 Prescription Card:  Yes  No Carrier: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

### CLINICAL ASSESSMENT

### PRESCRIPTION INFORMATION

Primary ICD-9 Code:  
 731.00—Paget's Disease  
 733.00—Osteoporosis Unspecified  
 733.10—Pathologic Fracture  
 733.01—Senile Osteoporosis – Post-menopausal  
 Other: \_\_\_\_\_

Weight: \_\_\_\_\_ Date: \_\_\_\_\_  
 Height: \_\_\_\_\_ Date: \_\_\_\_\_

Other Health Conditions:  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies:  
 \_\_\_\_\_  
 \_\_\_\_\_

Concomitant Medications:  
 \_\_\_\_\_  
 \_\_\_\_\_

Medication	Dose/Directions/Freq	Qty	Refills
<b>Aredia®</b> <input type="checkbox"/> 30 mg <input type="checkbox"/> 90 mg			
<b>Boniva® Injection</b> <input type="checkbox"/> 3 mg/3 mL			
<b>Forteo® Pen</b> <input type="checkbox"/> 600 mcg/2.4 mL <input type="checkbox"/> B-D—31 G—3/16" Mini UF Pen Needle			
<b>Prolia®</b> <input type="checkbox"/> 60 mg/mL Syringe <input type="checkbox"/> 60 mg/mL Vial			
<b>Reclast®</b> <input type="checkbox"/> 5 mg/100 mL			
Other: _____			
Other: _____			
Other: _____			

### PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_ Practice/Facility Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Fax: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_  
 State License #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI#: \_\_\_\_\_ Medicaid UPIN #: \_\_\_\_\_

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state specific required language to prohibit substitution: \_\_\_\_\_

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature Required: \_\_\_\_\_ Date: \_\_\_\_\_

**CONFIDENTIAL HEALTH INFORMATION:** Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

**IMPORTANT WARNING:** This is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employer or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.

Drug names are the property of their respective owners.