OSTEOPOROSIS PRESCRIPTION FORM

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.
Prescribers are reminded patients may choose any pharmacy of their choice.

Owl Specialty Pharmacy
1010 E. Arrow Hwy., Covina, CA 91724
Phone: 626-209-8169 Fax: 626-209-8171 or 855-817-9523
www.owlspecialty.com

Patient Information: please provide a copy of the patient's insurance card or information				
Patient Name:	**DOB:**	**Gender:** ☐ F ☐ M	**HT:**	**WT:**
Address:	**City:**	**State:**	**Zip Code:**	**Phone:**
Insurance:	**Subscriber's name:**	**ID#:**	**Group #:**	
Allergies: ☐ NKDA ☐ List allergies:				

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis / ICD-10:
- ☐ M80.0 **Age-related** osteoporosis **with** fracture
- ☐ M80.8 Other osteoporosis **with** fracture
- ☐ M81.**0 Age-related** osteoporosis **without** fracture
- ☐ M81.6 Localized osteoporosis
- ☐ M81.8 Other osteoporosis **without** fracture
- ☐ M85.9 Bone density and structure disorders
- ☐ M88.0 - M88.9 Paget's Disease
- ☐ M89.9 Disorder of bone, unspecified
- ☐ M94.9 Disorder of cartilage, unspecified
- ☐ Other: _____

BMD/T Score(s):	**Location(s):**	**Date:**	**New therapy for patient:** ☐ Yes ☐ No
Osteoporotic fracture - Date(s):	**Location(s):** ☐ None		**High risk patient:** ☐ Yes ☐ No

Risk factor(s) information:

Prior treatment: ☐ Yes ☐ No List therapy, start/end dates:

Comorbidities:	**Concomitant Medications:**

Injection Training Provided By: ☐ Physician's Office ☐ Pharmacy ☐ Other:

Medication	**Quantity / Strength**	**Directions**	**Refills**
☐ **Evenity®**	☐ 2 prefilled syringes (210 mg/2.34mL)	☐ Inject 2 syringes (210 mg total) SC every 4 weeks	
☐ **Forteo®**	☐ 1 prefilled pen (600 mcg/2.4 mL) with 30 needles ☐ 3 prefilled pens with 90 needles	☐ Inject 20 mcg SC once daily. Dispensed with BD Mini Pen Needles.	
☐ **Prolia®**	☐ 1 prefilled syringe (60 mg /1 mL)	☐ Inject 60 mg SC every 6 months in the upper arm, upper thigh or abdomen. To be administered by a healthcare professional.	
☐ **Reclast®**	☐ 1 vial (5 mg /100 mL)	Infusion given intravenously over no less than 15 minutes: ☐ Osteoporosis: 5 mg once a year ☐ Prevention of postmenopausal osteoporosis: 5 mg once every 2 years ☐ Paget's disease of bone: a single 5 mg infusion	
☐ **Tymlos™**	☐ 1 prefilled pen with 30 needles (3120 mcg/1.56 mL) ☐ 3 prefilled pens with 90 needles	☐ Inject 80 mcg SC once daily	

Prescriber Information				
Prescriber name:		**Phone:**	**Office contact name:**	
Prescriber address:	**City:**		**State:**	**Zip:**
NPI:	**DEA:**	**Fax and/or Email:**		
Prescriber signature:		**Date:**	☐ **DO NOT SUBSTITUTE**	