Bell Pharmacy

Osteoporosis Enrollment Form

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PATIENT INFORMATION

Name:	Date of Birth:			O Male O Female
Address:	City:	State:		Zip:
Phone:	Alt Phone:			Email:
SS #:	Primary Language:			Emergency Contact:

PRESCRIBER INFORMATION

Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:	City:	State:	Zip:	Tax ID:
Phone:	Fax:			Office Contact:

PRESCRIPTION INFORMATION

Needs by Date: Ship to: O Patients home O Prescriber 1st order only O Prescriber all orders O Other

Drug	Dose	Directions	Quantity	Refills
Boniva®	O Pre-filled Syringe	O Inject 3mg IV over 15-30 seconds every 3 months	3mg/3ml (1 syringe)	
Evenity	O Pre-filled Syringe	O Administer 210mg SQ once every month for 12 doses in the abdomen, thigh, or upper arm	105mg/ 1.17ml (1 syringe)	
Forteo®	O Pen	O Inject 20mcg SQ daily	600mcg/ 2.4ml (1 pen)	
		O Pen needles Size: O 5mm O 6mm. Use with Forteo daily as directed	30 days supply	
Prolia®	O Pre-filled Syringe	O Inject 60mg SQ once every 6 months	60mg/ml (1 syringe)	
Reclast® (Zoledronic Acid)	O Vial	O Infuse 5mg IV, over no less than 15 minutes, every year O Infuse 5mg IV, over no less than 15 minutes, every two years	1 vial	

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

Prior Failed Medication(s):	Length of Treatment	Reason for Discontinuing
Actonel	_____/_____/_____-_____/_____/_____	
Boniva	_____/_____/_____-_____/_____/_____	
Fosamax	_____/_____/_____-_____/_____/_____	
Prolia	_____/_____/_____-_____/_____/_____	
Reclast	_____/_____/_____-_____/_____/_____	
Other		

O Patient has not tried or failed any prior medication(s).

Diagnosis Date: _____/_____/_____

O M80.0 Age Related Osteoporosis with Fracture
O M80.8 Other Osteoporosis with Fracture
O M81.0 Age Related Osteoporosis without Fracture (Senile/Postmenopausal)
O M81.6 Localized Osteoporosis
O M81.8 Other Osteoporosis without Fracture
O M85.9 Disorder of Bone Density and Structure, Unspecified (Osteopenia)
O M89.9 Disorders of Bone, Unspecified
O M84.48XA to M84.40XA Pathological Fracture, Unspecified Site

Lowest Dexa T-score: _____ Site: _____ Date: _____/_____/_____

Fracture Site(s): _____ Date: _____/_____/_____

Does the patient have > 1 risk factor for fracture? O Yes O No

If Yes, please explain: _____

Will the patient be adequately supplemented with Calcium and Vitamin D?
O Yes O No

O Other:

Allergies:

Patient Height:_____ in/cm Weight: _____ kg/lbs

INJECTION TRAINING

O Patient has received pen and injection training O Physician's office to provide injection training O Parkway Pharmacy to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: Date

CONFIDENTIALITY NOTICE

Faxed Prescriptions will only be accepted from a prescribing practitioner.