



Patient Information – Please attach a copy of the patient’s insurance card

Patient Name:		Date of Birth:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		City:		State:	Zip:
Phone Number:		Alternate Phone Number:		Language:	
Allergies (Required):		<input type="checkbox"/> NKDA	Height:	Weight:	SSN:
Product Shipping Options: <input type="checkbox"/> Patient’s Home <input type="checkbox"/> Prescriber Office <input type="checkbox"/> Alternative Address:					

Prescriber Information					
Practice Name:			Office Contact:		
Prescriber:			NPI:		DEA:
Practice Address:		City:		State:	Zip:
Phone Number:		Fax Number:			

Clinical Information – Please send all available chart notes including lab results					
Diagnosis/ICD -10 :					
BMD/T -score:		Is the patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the patient have a history of osteoporotic fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of score:				If no, is the patient at high risk? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, date of fracture:					
Location of fracture:					
Prior Failed Medications: <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:					

Prescription Information				
Medication	Strength	Directions	Quantity	Refill
<input type="checkbox"/> Boniva®	3mg/ 3mL prefilled syringe	Inject the contents of 1 syringe (3 mg) intravenously every 3 months. To be administered by a healthcare professional	1 prefilled syringe	
<input type="checkbox"/> Forteo®	600 mcg/2.4 mL pen	Inject 1 dose (20 mcg) subcutaneously once daily. Discard device 28 days after first use. Dispensed with BD Mini™ Pen Needles (28 needles per 1 pen dispensed)	1 pen (4 weeks supply)	
<input type="checkbox"/> Prolia®	60 mg/1 mL prefilled syringe	Inject the contents of 1 syringe (60 mg) subcutaneously every 6 months	1 prefilled syringe	
<input type="checkbox"/> Tymlos™	2 mg/mL prefilled syringe	Inject 1 dose (80 mcg) subcutaneously once daily. Discard device 30 days after first use. Dispensed with BD Short™ Pen Needles (30 needles per 1 pen dispensed)	1 prefilled syringe	
<input type="checkbox"/> Other:				

PRESCRIBER SIGNATURE (PLEASE SIGN AND DATE BELOW)

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, the receipt and submission of patient lab values and other patient data including pursuing available copay and financial assistance on behalf of my patients. If this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient’s choice or in the patient’s insurer’s provider network.

Product substitution permitted Dispense as Written

Prescriber Signature: _____

_____ Date



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