OSTEOPOROSIS ENROLLMENT FORM
Fax to: 901-226-2496

BAPTIST

DATE:_____ DATE NEEDED: _____ **SHIP TO:** ☐ PATIENT ☐ OFFICE

PHARMACY LOCATION
6025 Walnut Grove Road, Suite 108
Memphis, TN 38120
Toll Free Phone: 844-605-5496

PATIENT INFO

NAME: _____ E-MAIL_____ DOB:_____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY_____ STATE_____ ZIP_____

HOME TELEPHONE:_____ MOBILE PHONE:_____ SS#__ __ __ - ___ ___ - ___ ___ ___ ___

INSURANCE INFO: *PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)*

CLINICAL INFORMATION

Diagnosis

● Date of Diagnosis: _____

- ☐ M88.9 Paget's Disease
- ☐ M80.80 Unspecified Osteoporosis
- ☐ M81.0 Postmenopausal/Senile Osteoporosis
- ☐ M81.8 Drug-induced Osteoporosis
- ☐ M80.88 Pathological Fracture of Vertebrae
- ☐ M80.85 Pathological Fracture of Neck of Femur
- ☐ M89.9 Unspecified disorder of bones ☐ M94.9 of cartilage

Primary Care Physician: _____

Primary Physician Phone #: _____

Patient Evaluation - General

- ● Treatment History: ☐ new to this medicine ☐ continued treatment
  - **If continuing on FORTEO®, what is start date of treatment? _____
  - *(Forteo® can be taken for a maximum of 24 months)*
- ● Allergies? ☐ None ☐ Latex ☐ Other: _____
- ● Patient weight: _____lb/kg
- ● Concomitant Medications:

Patient Evaluation - Osteoporosis

- ● Lowest Dexa T-Score: _____ Date of of Dexa: _____
- ● Fracture Site (if approp): Date of fracture:

Prior Failed Medication(s)	Length of Treatment	Reason for Discontinuing
	_____ to _____	
	to	

PRESCRIPTION INFORMATION

Drug	Dosage form/strength	Directions	Quantity	Refills
☐ Boniva®	☐ Prefilled Syringe (3mg/3ml)	☐ Inject 3mg IV over 15-30 seconds every 3 months	1 syringe *(3mg/3ml)*	
☐ Forteo®	☐ Pen (600ug/2.4ml) Delivery Device	☐ Inject 20mcg (0.08ml) SQ daily	1 pen *(600ug/2.4ml)*	
☐ Complimentary Needles ☐ 4mm 32G ☐ 5mm 31G ☐ 8mm 31G		☐ Use with Forteo® Delivery Device as directed	30	
☐ Please enroll patient in *FORTEO® Connect* patient support program				
☐ Prolia®	☐ Prefilled Syringe (60mg/ml)	☐ Inject 60mg SQ once every 6 months	1 pen *(60mg/ml)*	
☐ Zoledronic Acid	☐ Vial (5mg/100ml)	☐ Infuse 5mg IV, over no less than 15 minutes, every year ☐ Infuse 5mg IV, over no less than 15 minutes, every 2 years	1 vial *(5mg/100ml)*	

OTHER MEDICATIONS

Drug	Dosage form/strength	Directions	Quantity	Refills

Comments :

Injection Training

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ ReCept to coordinate injection training

MANUF SUPPORT: Please enroll patient in the product manufacturer-sponsored support program? ☐ **YES** ☐ **NO**

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person:_____

Telephone: _____ Fax:_____ Email:_____

Office Address: _____ City:_____ State: _____ Zip:_____

NPI # : _____ DEA # : _____ UPIN # : _____ Medicaid Provider # : _____

_____ _____ * _____

PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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