OSTEOPOROSIS SPECIALTY CARE PROGRAM

Phone: **844-805-3357** • Fax: **888-978-6171**

1 PATIENT INFORMATION:

Name: ____________________

Address: ____________________

City: ______________ State: ____ Zip: __________

Phone: ______________ Alt. Phone: ______________

Email: ____________________

DOB: __________ Gender: ❍ M ❍ F Caregiver: __________

Height: ________ Weight: ________ Allergies: ____________

2 PRESCRIBER INFORMATION:

Name: ____________________

Address: ____________________

City: ______________ State: ____ Zip: __________

Phone: ______________ Fax: ______________

NPI: ______________ DEA: ______________

Tax I.D.: ____________________

Office Contact: ______________ Phone: ______________

3 STATEMENT OF MEDICAL NECESSITY:

Date of Diagnosis: ____________

- ❑ 733.00 Osteoporosis
- ❑ 733.01 Senile Osteoporosis
- ❑ 733.02 Idiopathic Osteoporosis
- ❑ 733.03 Disuse Osteoporosis
- ❑ 733.09 Other Osteoporosis
- ❑ 733.10 Pathological Fracture
- ❑ V58.65 Long-Term Use of Steroids
- ❑ Other____________________

BMD/T-Score: ____________ Date: ____________

FRAX Score: ____________ Date: ____________

Is patient new to therapy? ❑ Yes ❑ No

Is patient high risk for fracture? ❑ Yes ❑ No

History of osteoporotic fracture? ❑ Yes ❑ No

If Yes, Location of Fracture: ____________________

Date of Fracture: ____________________

Contraindication(s) to bisphosphonate therapy? ❑ No ❑ Yes

If Yes: ❑ Dysphagia ❑ GERD ❑ Ulcer ❑ Other ______________

Please Attach All Medical Documentation Including:

❑ DEXA Scan ❑ Medication History ❑ CMP Panel ❑ Other Information Pertinent to the Case

Labs: Calcium: ____________ Vitamin D: ____________ Date: ____________

Prior Failed Treatments:	Length of Treatment:
❑ Actonel®	________________
❑ Boniva®	________________
❑ Forteo®	________________
❑ Fosamax®	________________
❑ Prolia®	________________
❑ Reclast®	________________
❑ Other	________________

4 PRESCRIPTION INFORMATION:

Medication	Dosage & Strength	Direction	QTY	Refills
❑ BONIVA®	❑ 3mg/3ml Prefilled Syringe	❑ Inject 3mg IV every 3 months	1	
❑ FORTEO®	❑ 600mcg/2.4ml Pen	❑ Inject 20mcg SC once daily	1	
❑ PROLIA®	❑ 60mg/ml Prefilled Syringe	❑ Inject 60mg SC every 6 months	1	
❑ PEN NEEDLES	❑ 31 Gauge ❑ 4mm ❑ 5mm ❑ 6mm			
❑ ____________	____________	____________		

5 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

6 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

7 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

8 PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ______________________________ Date: ____________

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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