

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: _____ Is patient new to therapy? Yes No
ICD-10: _____ Is patient high risk for fracture? Yes No
Other: _____ History of osteoporotic fracture? Yes No
BMD/T-Score: _____ Date: _____ FRAX Score: _____ Date: _____
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: _____

If Prior Authorization is Denied: Automatically Draft Appeal for Review Send Preferred Formulary Alternatives

Prior Failed Treatments:	Length of Treatment:
<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	_____

4 PRESCRIPTION INFORMATION:

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> FORTEO®	<input type="checkbox"/> 600mcg/2.4ml Pen	<input type="checkbox"/> Inject 20mcg SC once daily	1	
<input type="checkbox"/> PEN NEEDLES	<input type="checkbox"/> 31 Gauge <input type="checkbox"/> 5mm		30	
<input type="checkbox"/> PROLIA®	<input type="checkbox"/> 60mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 60mg SC every 6 months	1	
<input type="checkbox"/> _____	_____	_____		

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: _____ Signature: _____ Date: _____
Substitution Permitted **Dispense As Written**
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.