Osteoporosis Enrollment Form

Phone: 800-476-7496
Fax: 888-985-9223

PATIENT INFORMATION

Patient Name (Last, First, Mi)			☐ Male ☐ Female	
Date of Birth	SS#	Phone (Home)	(Work)	
Address		City	State	Zip

INSURANCE INFORMATION (PLEASE ATTACH COPY OF PATIENT CARD – FRONT AND BACK)

Primary Insurance		Policy Holder
Policy #	Group #	Phone

DIAGNOSIS / MEDICAL INFORMATION (Please indicate primary and secondary diagnosis)

☐ 733.00 Osteoporosis, Unspecified ☐ 733.01 Senile/Postmenopausal Osteoporosis ☐ 733.02 Idiopathic Osteoporosis

☐ 733.03 Disuse Osteoporosis ☐ 733.02 Other Osteoporosis ☐ Other ICD Code & Name: ______________________

Patient Weight: ___________________ Drug Allergies: _____________________ OR ☐ NKDA Is patient new to therapy? ☐ yes ☐ no
Date of Diagnosis: _____/______/______

History of osteoporotic fracture? ☐ Yes ☐ No If no, is patient at high risk? ☐ Yes ☐ No If yes, date of fracture ___/___/___ Location: __________

PREVIOUS MEDICATIONS (Please specify dosage and time on therapy)

Medication Strength and Dose	*Date of Therapy*	*Reason for Discontinuing*

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	SIG / DIRECTIONS	QUANITY	REFILLS
☐ Boniva®	☐ 3 mg/3 ml PFS Kit	☐ Infuse 3 mg IV push every months. To be administered by a healthcare Professional.	☐ 1 dose / 3 month supply	
☐ Forteo®	☐ 600 mcg/2.4 ml Pen Include needle? ☐ 29G ☐ 30/31G ☐ 32G	☐ Inject 20 mcg/0.8 ml SC once daily	☐ 1 Pen (4 week supply) ☐ 3 Pens (12 week supply)	
☐ Prolia®	☐ 60 mg/1 ml PFS ☐ 60 mg/1 ml vial	☐ Inject 60 mg/1 ml SC every 6 months	☐ 1 Pre-Filled Syringe or vial	
☐ Reclast®	☐ 5mg 100 ml vial	☐ Infuse 5 mg IV over 15-20 minutes, once per year (annually). To be administered by a healthcare Professional.	☐ 1 - 5mg 100 ml vial	

DELIVERY AND PATIENT EDUCATION INSTRUCTIONS

Deliver to: ☐ Patient's Home ☐ Physician's Office | Date Needed: ______/_______/________ | Patient needs Education Kit? ☐ yes ☐ no

Teaching to be done at: ☐ Patient's Home ☐ Physician's Office ☐ Not needed

PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION

Physician Name		License #	DEA #	UPIN#
Office Contact	Phone	Fax	NPI#	
Address		City/State/Zip		
Physician's Signature (required)			Date (required)	

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.