OSTEOPOROSIS DISEASE ENROLLMENT FORM

PATIENT INFORMATION

Last Name _____ First Name _____

Social Security No _____ Date of Birth _____

Sex □ M □ F Weight_____ Height_____

Home Phone _____ Work/Mobile _____

Home Address _____

City _____ State _____ Zip _____

PATIENT INSURANCE INFORMATION

Primary Medical Insurance _____ Medical Insurance Phone _____

Subscriber Name _____

Rx Card (PBM) _____ Group No _____

Prescription Card Bin # _____ PCN # _____

TREATMENT ARRANGEMENTS

•Start Date:_____ Ship Meds □ Home □ Doctor's Office

Teaching by: □ Doctor's Office □ Other:_____

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD-10 CODE): □ M81.0 Osteoporosis □ M80.0 Osteoporosis with fracture □ _____ Date of Diagnosis: _____

Is patient using prescribed therapy in combination with other biologics for MS? □ Yes □ No

IS patient pregnant, Nursing, Or Planning pregnancy? □ Yes □ No □ N/A Allergies: _____

Patient Evaluation:

- Does the patient have any of the following conditions?
- Unexplained elevations of alkaline phosphatase □ Yes □ No
- Open epiphysis (i.e., pediatric or young adult patient) □ Yes □ No
- Prior radiation therapy involving the skeleton □ Yes □ No
- Bone metastases □ Yes □ No
- Metabolic bone disease other than osteoporosis □ Yes □ No
- Pre - existing hypercalcemia □ Yes □ No
- Is the patient currently taking a bisphosphonate? □ Yes □ No

- Is the patient high risk for fracture □ Yes □ No
- Allergies: _____
- Patient Weight : _____ kgs/lbs
- Patient Heights : _____ inches

If Yes to previous question, will current bisphosphonate therapy be discontinued upon induction Forteo® or Tymlos® □ Yes □ No □ FRAX #_____

- For patients continuing Forteo® therapy, how long have they been taking Forteo® or Tymlos® _____ Months
- Does the patient have hypocalcemia? □ Yes □ No
- Will the patient be supplemented with calcium and vitamin D? □ Yes □ No

Bone Mineral Density Result:

- DXA Result (g/cm2): _____ T-Score: _____ Date: _____
- DXA Result (g/cm2): _____ T-Score: _____ Date: _____

Fracture History:

Site: _____ Date: _____

Site: _____ Date: _____

Prior (Failed) Medications:

Medication	*Strength*	*Duration of Treatment/Reason for Discontinuation*
_____	_____	_____
_____	_____	_____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
□ **EVENITY®**	□ 210mg	□ Inject 210mg SubQ Once every month.		
□ **BONIVA®**	□ 3mg/3ml	□ Inject 3mg IV every 3 months.		
□ **TYMLOS®** □ **PEN NEEDLES**	□ 3120mcg/1.56ml 31 gauge □ 5mm □ 6mm □ 8mm	□ Inject 80mcg SubQ once daily. Use with Tymlos® Delivery Device daily.	30days □ 1 Device(4-week supply) □ 3 Devices (12– week supply) 1 Box (100ct)	
□ **FORTEO®** □ **PEN NEEDLES**	□ 600mcg/2.4ml Device 31 gauge □ 5mm □ 6mm □ 8mm	□ Inject 20mcg (0.08ml) SubQ once daily. Use with Forteo® Delivery Device daily.	□ 1 Device(4-week supply) □ 3 Devices (12– week supply) 1 Box (100ct)	
□ **PROLIA®**	□ 1 single use Prefilled Syringe	□ Inject 60mg SubQ every 6 months.		
□ **RECLAST®**	□ 5mg	□ Infuse 5mg IV once a year.	□ 1 Vial	
□				

Physician Signature: X_____ □ **DAW (Dispense as Written) Date:** _____

Physician Name: _____ **Phone:** _____ **Fax:** _____ **Office Contact:** _____

Physician Address: _____ **NPI:** _____ **DEA:** _____

X By Signing this prescription & using Southside's services, you are authorizing Southside to contact insurance companies for prior authorizations on behalf of your practice.

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