

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

Fracture History:

Prior (Failed) Medications:

<i>Medication</i>	<i>Strength</i>	<i>Duration of Treatment/Reason for Discontinuation</i>
_____	_____	_____

PRESCRIPTION INFORMATION

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

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

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

Physician Address: _____ NPI: _____ DEA: _____

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