SPECIALTY PHARMACY™
Osteoporosis Enrollment Form

Pharmacy Phone: ______________________

Fax completed forms and prescriptions to ______________________ or electronically prescribe to ______________________

Date Needed: ____________ Preferred Pharmacy Pickup Location: ______________________

Patient Information

Patient Name: ______________________ DOB: __________ ☐ Male ☐ Female

Address: ______________________ City: __________ State: _____ ZIP Code: __________

Phone: ______________________ Email address: ______________________

Insurance Provider (Please include a copy of front and back of card): ______________________

ID #: ______________ Policy/Group #: ______________ Phone #: ______________

Name of Insured: ______________ Relationship to Insured: ______________ Employer: ______________

Prescription Card: ☐ Yes ☐ No Carrier: ______________________ Policy/Group #: ______________

Clinical Assessment

Diagnosis/ICD 9:

- ☐ 733.00 Osteoporosis, unspecified
- ☐ 733.01 Senile Osteoporosis
- ☐ 733.02 Idiopathic Osteoporosis
- ☐ 733.03 Disuse Osteoporosis
- ☐ 733.09 Other Osteoporosis
- ☐ V58.65 Long-term (current) use of steroids
- ☐ Other: ______________________

BMD/T-Score: ______________________

Date: ______________________

Is patient new to therapy? ☐ Y ☐ N

History of osteoporotic fracture? ☐ Y ☐ N

If yes, date of fracture: ______________

If yes, location of fracture: ______________

If no, is patient at high risk? ☐ Y ☐ N

Prior Failed Therapies:

- ☐ Actonel® Date(s): __________
- ☐ Boniva® Date(s): __________
- ☐ Forteo® Date(s): __________
- ☐ Fosamax® Date(s): __________
- ☐ Prolia® Date(s): __________
- ☐ Reclast® Date(s): __________
- ☐ Other (please specify) ______________________

Prescription Information

Medication	Dose	Directions/Frequency	Quantity	Refills
☐ Forteo®	☐ 600 mcg/2.4 mL Pen	Inject 1 dose (20 mcg) subcutaneously once daily Discard device 28 days after first use	☐ 1 Pen (4 weeks) ☐ 3 Pens (12 weeks)	
☐ BD® Mini Pen Needles	☐ 31G x 3/16”	Use with Forteo® pen once daily as directed	1 Box	
☐ Prolia®	☐ 60 mg/1 mL PFS	Inject the contents of 1 syringe (60 mg) subcutaneously every 6 months	1 Pre-Filled Syringe	
☐ Boniva®	☐ 3 mg/3 mL PFS	Inject the contents of 1 syringe IV every 3 months To be administered by a healthcare professional	1 Pre-Filled Syringe	

Prescriber Information

Prescriber’s Name: ______________________ Practice/Facility Name: ______________________

Prescriber NPI/DEA #: ______________________ Contact: ______________________

Address: ______________________ City: __________ State: _____ ZIP Code: __________

Phone: ______________ Fax: ______________ Best Time to Call: ______________

Prescriber’s Signature: ______________________ Date: ______________

Pharmacy can accept only original hardcopy prescription drug orders from patients. Faxed prescriptions must be sent directly from prescribing practitioners.