

## Osteoporosis

Delivery Need By:	Deliver to:	🗆 Patien	nt's Home 🛛 Physician's Office 🗆 Other		
PATIENT INFORMATION			PRESCRIBER INFORMATION		
Patient Name:		🗆 Male	Prescriber's Name:		
Address:		🗆 Female	Office Contact Name:		
City: State			Address:		
Phone Number:			City: State: Zip:		
Email Address: Last Four of Social:	DOB:		Phone Number: Fax: DEA/NPA #:		

## **INSURANCE - PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK**

CLINICAL INFORMATION						
Diagnosis:		Has the patient been treated previously for this condition?				
ICD-10 Code: _		🗆 Yes 🗆 No				
Height: ft inches Weight: lbs		Medications Failed:				
Allergies:		Medications On:				
/e. g.ee		Other Notes:				
PRESCRIPTION INFORMATION						
Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:		
Evenity	□ 105 mg/1.17ml prefilled syringe	□ Inject 210mg (two syringes one after the other) once a month for twelve months SC by a health care provider	<ul> <li>2 syringes (60 day supply)</li> <li>6 syringes (90 day suppy)</li> </ul>			
Forteo <sup>®</sup>	□ 600mcg/2.4ml pen	□ Inject 20mcg SC once daily	<ul> <li>1 Device (4 week supply)</li> <li>3 devices (12 week supply)</li> <li>Other</li> </ul>			
□ 31G Pen Needles □ 5mm □ 6 mm □ 8mm		□ Use with Forteo® as directed	□ 28 day supply □ 84 day supply			
Prolia ®	□ 60 mg/1ml prefilled syringe	□ Inject 60mg SC every 6 months	□1 syringe			
Reclast <sup>®</sup>	□ 5 mg/100 ml ready-to-infuse solution	🗆 Infuse 5 mg once a year	□ vials			
Tymlos*	□ 2000mcg/Ml, 1.5ML Pen	□ Inject 80mcg SC once daily	<ul> <li>1 device (30 day supply)</li> <li>3 devices (90 day supply)</li> <li>Other</li> </ul>			
□ 31G Pen Needles □ 5mm □ 6 mm □ 8mm		$\Box$ Use with Tymlos® as directed	□ 30 day supply □ 90 day supply			
Other						
□ Patient is interested in patient support programs □ Ancillary supplies provided for administration						

Physician Signature: \_\_\_

Date: \_\_\_

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