Osteoporosis

Delivery Need By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other _____

PATIENT INFORMATION

Patient Name: _____ ☐ Male
Address: _____ ☐ Female
City: _____ State: _____ Zip:_____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPA #: _____

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ inches Weight: _____ lbs

Allergies: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____
Medications On: _____
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	☐ 2 syringes (60 day supply) ☐ 6 syringes (90 day suppy)	
Forteo®	☐ 600mcg/2.4ml pen	☐ Inject 20mcg SC once daily	☐ 1 Device (4 week supply) ☐ 3 devices (12 week supply) ☐ Other	
☐ 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®	☐ 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	☐ 1 device (30 day supply) ☐ 3 devices (90 day supply) ☐ Other	
☐ 31G Pen Needles ☐ 5mm ☐ 6 mm ☐ 8mm		☐ 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: _____