

**Osteoporosis**

Ph: (214) 919-2090 or (877) 753-6878

Fax: 1 (888) 294-9434

Injection Training:	<input type="checkbox"/> MD Office
	<input type="checkbox"/> Pharmacy to Arrange
Ship To:	<input type="checkbox"/> Patient Home <input type="checkbox"/> MD Office

<b>MAIN POINT OF CONTACT</b>
Name: _____
Phone: _____

<b>PATIENT INFORMATION (Use this area or attach patient demographics)</b>				
Name: _____	Phone: _____	Phone 2: _____		
Home Address: _____	City: _____	State: _____	Zip Code: _____	
DOB: _____	SSN: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height: _____	Weight: _____ lbs.
Emergency Contact: _____	Phone: _____			

<b>INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))</b>				
Primary Insurance: _____	Secondary Insurance: _____			
ID#: _____	RxBin: _____	ID#: _____	RxBin: _____	
RxGroup: _____	Pcn: _____	RxGroup: _____	Pcn: _____	

<b>DIAGNOSIS:</b>																	
<input type="checkbox"/> M81.0 Age-related osteoporosis without current pathological fracture <input type="checkbox"/> M81.8 Other osteoporosis without current pathological fracture <input type="checkbox"/> Z79.51 Long term (current) use of inhaled steroids <input type="checkbox"/> Z79.52 Long term (current) use of systemic steroids <input type="checkbox"/> Other: _____	Prior (FAILED) Therapy: <table border="0"> <tr> <td>Therapy</td> <td>Date(s)</td> </tr> <tr> <td><input type="checkbox"/> Fosamax</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Actonel</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Boniva</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Prolia</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Reclast</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Forteo</td> <td>_____</td> </tr> <tr> <td>Other:</td> <td>_____</td> </tr> </table>	Therapy	Date(s)	<input type="checkbox"/> Fosamax	_____	<input type="checkbox"/> Actonel	_____	<input type="checkbox"/> Boniva	_____	<input type="checkbox"/> Prolia	_____	<input type="checkbox"/> Reclast	_____	<input type="checkbox"/> Forteo	_____	Other:	_____
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<input type="checkbox"/> Reclast	_____																
<input type="checkbox"/> Forteo	_____																
Other:	_____																
Date of Diagnosis: _____ BMD/T-Score: _____ Is patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
History of osteoporotic fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
If Yes, date of fracture: _____ Locatio of fracture: _____																	
If No, is patient at high risk? <input type="checkbox"/> Yes <input type="checkbox"/> No																	

Medication	Strength	Directions	Qty.	Refills
<input type="checkbox"/> Forteo	<input type="checkbox"/> 600 mcg/2.4 mL Pen	<input type="checkbox"/> Inject 1 dose (20 mcg) subcutaneously once daily. Discard device 28 days after first use.	<input type="checkbox"/> 1 Pen (4 week supply) <input type="checkbox"/> 3 Pens (12 week supply)	
<input type="checkbox"/> BD Mini Pen Needles	<input type="checkbox"/> 31G x 3/16"	<input type="checkbox"/> Use with Forteo pen once daily as directed	<input type="checkbox"/> #100 Pen Needles <input type="checkbox"/> #30 Pen Needles	
<input type="checkbox"/> Prolia	<input type="checkbox"/> 60 mg/1mL PFS	<input type="checkbox"/> Inject the contents of 1 syringe (60 mg) subcutaneously every 6 months	<input type="checkbox"/> 1 Prefilled Syringe	
<input type="checkbox"/> Reclast	<input type="checkbox"/> 5 mg/100mL vial	<input type="checkbox"/> Infuse 5 mg intravenously over no less than 15 minutes once annually	<input type="checkbox"/> One: 5mg/100mL vial	0
<input type="checkbox"/> Boniva	<input type="checkbox"/> 3 mg/3mL PFS	<input type="checkbox"/> Inject the contents of 1 syringe (3 mg) intravenously every 3 months. to be administered by a healthcare professional	<input type="checkbox"/> One: 3mg/3mL PFS	



**ALL controlled substance quantities must be hand written in number and letter form**

Prescriber Name: _____	NPI#: _____
Address: _____	City: _____ State: _____ Zip Code: _____
Phone: _____	Fax: _____

<b>*Prescriber Signature:</b> _____	<b>Date:</b> _____
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