ASP CARES

Osteoporosis

Ph: (214) 919-2090 or (877) 753-6878
Fax: 1 (888) 294-9434

MAIN POINT OF CONTACT
Name:_____
Phone:_____

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____
Home Address:_____ City:_____ State:_____ Zip Code:_____
DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____lbs.
Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:_____ Secondary Insurance:_____
ID#:_____ RxBin:_____ ID#:_____ RxBin:_____
RxGroup:_____ Pcn:_____ RxGroup:_____ Pcn:_____

DIAGNOSIS:

☐ M81.0 Age-related osteoporosis without current pathological fracture
☐ M81.8 Other osteoporosis without current pathological fracture
☐ Z79.51 Long term (current) use of inhaled steroids
☐ Z79.52 Long term (current) use of systemic steroids
☐ Other:_____

Prior (FAILED) Therapy:

Therapy	Date(s)
☐ Fosamax	_____
☐ Actonel	_____
☐ Boniva	_____
☐ Prolia	_____
☐ Reclast	_____
☐ Forteo	_____
Other:	_____

Date of Diagnosis:_____ BMD/T-Score:_____ Is patient new to therapy? ☐ Yes ☐ No

History of osteoporotic fracture? ☐ Yes ☐ No
If Yes, date of fracture:_____ Locatio of fracture:_____

If No, is patient at high risk? ☐ Yes ☐ No

Medication	Strength	Directions	Qty.	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 week supply) ☐ 3 Pens (12 week supply)	
☐ BD Mini Pen Needles	☐ 31G x 3/16”	☐ Use with Forteo pen once daily as directed	☐ #100 Pen Needles ☐ #30 Pen Needles	
☐ Prolia	☐ 60 mg/1mL PFS	☐ Inject the contets of 1 syringe (60 mg) subcutaneously every 6 months	☐ 1 Prefilled Syringe	
☐ Reclast	☐ 5 mg/100mL vial	☐ Infuse 5 mg intravenously over no less than 15 minutes once annually	☐ One: 5mg/100mL vial	0
☐ Boniva	☐ 3 mg/3mL PFS	☐ Inject the contents of 1 syringe (3 mg) intravenously every 3 months. to be administered by a healthcare professional	☐ 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:_____

***Prescriber Signature:_____Date:_____**

Please fax completed form to 1 (888) 294-9434