

First ship to: Patient Physician

Need by date:

Patient

Patient name:			
Date of birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight: lb/kg
Address:		City:	State: ZIP:
Home number:	Work number:	Cell number:	Best time to call: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Social Security number:		Ethnicity:	
Primary language:		Allergies:	<input type="checkbox"/> NKDA

Provider

Physician name:		Practice name	
NPI number:		State license number:	
Address:		City:	State: ZIP:
DEA number:		Phone number:	Fax number:
Key office contact name:		Phone number:	

Insurance*

Primary insurance:	ID number:	Phone:
Secondary insurance:	ID number:	Phone:
Pharmacy BIN:	Pharmacy PCN:	Pharmacy Group No.:

*Please provide a copy of the insurance card (front and back).

Clinical Information

Diagnosis: <input type="checkbox"/> Osteoporosis (ICD: _____) <input type="checkbox"/> Other _____ (ICD: _____)	
<input type="checkbox"/> The patient is taking calcium and vitamin D	Is Patient at risk for osteoporotic fracture as evident by any of the following? (Check all that apply) <input type="checkbox"/> History of osteoporotic fracture Site: _____ Date: _____ <input type="checkbox"/> Patient has tried and failed an oral bisphosphonate: _____ <input type="checkbox"/> Patient has documented contraindication AND/OR intolerant to oral bisphosphonate therapy (please submit a copy of DEXA w/prescription) _____
TB/PPD Test: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A Test date:	
Previously treated: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list therapy:	Dates:

Prescription Information

Medication	Dose/Strength	SIG	Quantity	Refills
<input type="checkbox"/> Boniva®	3mg/3mL PFS	Infuse 3 mg IV over a period of 15 to 30 seconds every 3 months	1 dose	
<input type="checkbox"/> Forteo®	600mcg/2.4 mL pen	Inject 20mcg SubQ. as directed once daily <input type="checkbox"/> Dispense with pen needles: <input type="checkbox"/> 31gx6mm UF <input type="checkbox"/> Other: _____	1 pen	
<input type="checkbox"/> Prolia®	60mg/1mL PFS	Inject 60mg SubQ every 6 months	1 dose	
<input type="checkbox"/> Reclast® (Zoledronic acid solution)	5mg/100mL	Infuse 5mg IV over no less than 15 minutes.	1 dose	
<input type="checkbox"/> Tymlos®	3120mcg/1.56 mL pen	Inject 80 mcg subcutaneously once daily.	1 pen	
<input type="checkbox"/> Other: _____				

PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS. (STAMPS NOT ACCEPTED)

Prescriber Signature:		Prescriber Signature:	
<input type="checkbox"/> Dispense as written/Do not substitute	Date	<input type="checkbox"/> Substitution permitted/Branded exchange permitted	Date

For states requiring handwritten expressions of product selection, use this area (e.g. medically necessary, may not substitute, dispense as written, etc.)

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