

Osteoporosis



toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient information	Prescriber + Shipping Information
Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1 st Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____ Insurance Plan: _____ Plan ID # _____ Please fax a copy of front and back of the insurance card(s).	Prescriber Name: _____ NPI #: _____ Address: _____ Apt/Suite # _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address _____ If shipping to prescriber: <input type="checkbox"/> 1st Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis ICD-10:

- | | | |
|---|--|--|
| <input type="checkbox"/> M80.0 Age-related osteoporosis with fracture | <input type="checkbox"/> M80.8 Other osteoporosis with fracture | <input type="checkbox"/> M81.0 Age-related osteoporosis without fracture |
| <input type="checkbox"/> M81.6 Localized Osteoporosis | <input type="checkbox"/> M81.8 Other osteoporosis without fracture | <input type="checkbox"/> M85.9 Bone density and structure disorders |
| <input type="checkbox"/> M88.0 – M88.9 Paget's Disease | <input type="checkbox"/> M89.9 Disorder of bone, unspecified | <input type="checkbox"/> M94.9 Disorder of cartilage, unspecified |
| <input type="checkbox"/> Other: _____ | | |

BMD/T-Score(s): _____ Location(s): _____ Date: _____ New therapy for patient? ☐ Yes ☐ No
 Osteoporotic fracture – Date(s): _____ Location(s): _____ ☐ None High risk patient? ☐ Yes ☐ No
 Risk factor(s) Information: _____ Any prior treatment: ☐ No ☐ Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: _____
 Concomitant Medications: _____
 Allergies: ☐ NKDA ☐ Other: _____

Prescription information

<input type="checkbox"/> Boniva®	<input type="checkbox"/> Inject the contents of 1 PFS intravenously every 3 months. To be administered by a healthcare professional. Qty: <input type="checkbox"/> 1 PFS (3 mg/3 mL) Refills: _____
<input type="checkbox"/> Forteo®	<input type="checkbox"/> Inject 20 mcg SQ once daily. Discard device 28 days after first use. Dispensed with BD Mini™ Pen Needles. Qty: 30 Needles per 1 Pen (600 mcg/2.4 mL) <input type="checkbox"/> 1 Pen with 30 Needles <input type="checkbox"/> 3 Pens with 90 Needles Refills: _____
<input type="checkbox"/> Prolia®	<input type="checkbox"/> Inject contents of 1 PFS SQ every 6 months. Qty: <input type="checkbox"/> 1 PFS (60 mg/1 mL) Refills: _____
<input type="checkbox"/> Reclast®	<input type="checkbox"/> Infuse 5 mg intravenously over no less than 15 minutes once annually. Qty: <input type="checkbox"/> 1 Vial (5 mg/100 mL) Refills: _____
<input type="checkbox"/> Tymlos®	Inject 80mcg/40mL SQ once daily Qty: <input type="checkbox"/> 1 Pen, 30 day supply Refills: _____ Include BD Mini Pen Needles (#100)

Injection Training Provided By: ☐ Physician's office ☐ Pharmacy ☐ Other: _____

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Prescriber's Signature: _____ Date: _____

I authorize Thrifty White Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Thrifty White Specialty Pharmacy.

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