Osteoporosis



Prescriber Name:	Patient information			Prescriber + Shipping Information			
New therapy for patient? Location(s): Date: New therapy for patient? Test Do None High Transport for Therapy Reason for Discontinuation of Therapy Approximate Start Date Approximate End Date Approximate Start Date Approximate Start Date Approximate End Date Approximate Start Date Approximate End Date Approximate Start Date Approximate End Date Approximate Start Date Approximate Start Date Approximate Start Date Approximate End Date Approximate Start Date Approximate Start Date Approximate Start Date Approximate End Date Approximate Start Date Approximate End Date Approximate Start Date Approximate End Dat	Patient Name: DOB:			Prescriber Name:			
Address:	Sex: ☐ Female ☐ Male	SS #:		NPI #:			
Aptibulie: City: State: Zip: Contact:			□lbs Ht:□cm □in		Address:		
Phone:	Address:City:		State: 7in:	Apt/Suite # C	ity: State	e: Zip:	
Caregiver name:							
Local Pharmacy:				Phone: Alternate:			
Please fax a copy of front and back of the insurance card(s). If shipping to prescriber: 1st Fill Always Never Clinical Information (Please fax all pertinent clinical and lab information)				Fax:			
Clinical Information (Please fax all pertinent clinical and lab Information) Diagnosis ICD-10:							
Diagnosis ICD-10:	Please fax a copy of fr	ont and back of the in	surance card(s).	If shipping to prescriber	: 1st Fill Always Ne	ever	
M80.0 Age-related osteoprosis with fracture M80.8 Other osteoprorsis with fracture M81.0 Age-related osteoprosis without fracture M81.0 Age-related osteoprosis without fracture M85.9 Bone density and structure disorders M89.9 Disorder of bone, unspecified M94.9 Disorder of cartilage, unspecified M94.9 Disord	-	(Please fax all perti	nent clinical and lab info	ormation)			
M81.6 Localized Osteoporosis	Diagnosis ICD-10:						
M88.0 - M88.9 Paget's Disease	☐ M80.0 Age-related osteoporosis with fracture ☐ M80.8 Other osteoporosis with fracture ☐ M81.0 Age-related osteoporosis without fracture						
Other: MOIT-Scorre(s):	☐ M81.6 Localized Osteoporosis ☐ M81.8 Other osteoporosis without fracture ☐ M85.9 Bone density and structure disorders						
BMD/T-Score(s): _ Location(s): _ Date: _ New therapy for patient? □ Yes □ No Osteoportic fracture - Date(s): _ Location(s): _ □ None High risk patient? □ Yes □ No Risk factor(s) Information: Any prior treatment: □ No □ Yes □ Yes □ No □ Yes □ No □ Yes □ Yes □ Yes □ No □ Yes □ Yes □ Yes □ No □ Yes □	☐ M88.0 – M88.9 Paget's Disease ☐ M89.9 Disorder of bone, unspecified ☐ M94.9 Disorder of cartilage, unspecified						
Osteoportic fracture - Date(s):	□ Other:						
Reason for Discontinuation of Therapy Reason for Discontinuation of Therapy Approximate Start Date Approximate End Date Approxima	BMD/T-Score(s):	Location(s)	:	Date:	New therapy for	patient? ☐ Yes ☐ No	
Reason for Discontinuation of Therapy	Osteoportic fracture - D	oate(s):	Location(s):		None High risk	c patient? ☐ Yes ☐ No	
Comorbidities: Concomitant Medications: Allergies: □ NKDA □ Other: Prescription information □ Boniva® □ Inject the contents of 1 PFS intravenously every 3 months. To be administered by a healthcare professional. Oty: □ 1 PFS (3 mg/3 mL) Refills: □ Inject 20 mcg SQ once daily. Discard device 28 days after first use. Dispensed with BD Mini™ Pen Needles. Oty: 30 Needles per 1 Pen (600 mcg/2.4 mL) □ 1 Pen with 30 Needles □ 3 Pens with 90 Needles Refills: □ Prolia® □ Inject contents of 1 PFS SQ every 6 months. Oty: □ 1 PFS (60 mg/1 mL) Refills: □ Inject 80 mg/100 mL) Refills: □ Tymlos® □ Inject 80 mg/40 mcL SQ once daily Oty: □ 1 Pen, 30 day supply 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: Pations Pation Pation	Risk factor(s) Information: Any prior treatment: \square No \square Yes (provide information below)						
Concomitant Medications: Allergies: NKDA Other: Prescription Information Boniva® Inject the contents of 1 PFS intravenously every 3 months. To be administered by a healthcare professional. Oty: 1 PFS (3 mg/3 mL) Refills: Forteo® Inject 20 mcg SQ once daily. Discard device 28 days after first use. Dispensed with BD Mini™ Pen Needles. Oty: 30 Needles per 1 Pen (600 mcg/2.4 mL) 1 Pen with 30 Needles 3 Pens with 90 Needles Refills: Prolia® Inject contents of 1 PFS SQ every 6 months. Oty: 1 PFS (60 mg/1 mL) Refills: Reclast® Infuse 5 mg intravenously over no less than 15 minutes once annually. Oty: 1 Vial (5 mg/100 mL) Refills: Tymlos® Inject 80mcg/40mcL SQ once daily Oty: 1 Pen, 30 day supply Refills: Inject bon Training Provided By: Physician's office Pharmacy Other: Prescriber's Signature: Prescriber's Signature: Date: Lautoce Thinly White Society Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior subtrotation process for this prescription and any future than the first of the same prescriptor for the prescriptor and any future than the first of the same prescriptor for the prescriptor and any future than the first of the same prescriptor for the prescriptor and any future than the first of the same prescriptor for the prescriptor and any future than the first of the same prescriptor for the prescriptor and any future than the first of the same prescriptor for the prescriptor and any future than the first of the same prescriptor for the prescriptor and any future than the first of the same prescriptor for the prescriptor and any future than the first of the same prescriptor for the prescriptor and any future than the first of the same prescriptor for the prescriptor and any future than the first of the prescriptor and any future than the first of the prescriptor and any future than the first of the prescriptor and any future than the first of the prescriptor and any future than the fi	Prior Therapy	rior Therapy Reason for Discontinuatio		n of Therapy	Approximate Start Date	Approximate End Date	
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□ Tymlos®		Gty. 2 1 Viai (5 mg/100 mz)			Keli	IIS	
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