



# OSTEOPOROSIS ENROLLMENT/PRESCRIPTION FORM

Customer Service Phone 1-800-850-9122

Fax 1-800-218-3221

## PATIENT INFORMATION

Last Name	First Name	MI	ID Number
Home Address		City, State	Zip / /
Shipping Address (if different from home address)		Ship to MD ( )	Home Phone Number ( ) Work Phone Number ( )

## INSURANCE INFORMATION

(fill out entirely or fax a copy of patient's Insurance card, both sides)

Primary Insurance	Secondary Insurance
Policy Number	Policy Number
Group Number	Group Number

## PRIMARY DIAGNOSIS

DIAGNOSIS Postmenopausal Osteoporosis with high risk of fracture (Female) Hypogonadal Osteoporosis with high risk of fracture (Male) Prophylaxis, postmenopausal osteoporosis Other: _____	Treatment/prophylaxis, glucocorticoid-induced osteoporosis Paget's disease
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## MEDICAL INFORMATION

Start Date of Therapy: \_\_\_\_\_ (Forteo no to exceed 2 years of therapy)    Initiation of Therapy    Continuation of Therapy

Height: \_\_\_\_\_ Cm    In    Weight: \_\_\_\_\_ Lbs.    Kg    Date Measurement: \_\_\_\_\_    See Attached

Serum Calcium: \_\_\_\_\_    Bone Mineral Density: \_\_\_\_\_    Creatinine Clearance: \_\_\_\_\_    See Attached

Notes: \_\_\_\_\_

Allergies: \_\_\_\_\_    NKDA

Current Medications: \_\_\_\_\_    See Attached

Previous Treatment with:    Bisphosphonates (Actonel, Fosamax)    Calcitonin    Estrogen Replacement    Other \_\_\_\_\_

Reason for Discontinuation: \_\_\_\_\_    See Attached

## PRESCRIPTION INFORMATION

<b>Forteo 600mcg/2mL Pen</b>  Inject 20 mcg (0.08 mL) SQ daily   Qty _____ Refill x _____	<b>Reclast 5 mg/100 mL</b>  Osteoporosis, prophylaxis- 5mg IV over no less than 15 minutes every 2 years  Osteoporosis, treatment- 5mg IV over no less then 15 minutes once yearly  Paget's disease- 5mg IV over no less than 15 minutes (patient should receive 1,500mg elemental calcium and 800 IU vitamin D daily, particularly during the first two weeks after dosing)  Qty _____ Refill x _____
<b>Boniva Injection</b>  Inject 3mg IV over 15-30 seconds every 3 months (to be administered by a healthcare professional)   Qty _____ Refill x _____	<b>Other</b>     Qty _____ Refill x _____

## PRESCRIBER INFORMATION

Prescriber Name	Specialty	Office Contact	Phone Number ( )
Address		City, State	Zip Fax Number ( )
Today's Date	Date Needed By	DEA	On File NPI    On File

I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge.

Prescriber's Signature

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist. For refills, please call-in or fax 7 days in advance of next appointment.

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