phone: 1.877.829.3137
fax: 1.417.869.0277

Osteoporosis

Patient information

Patient Name: ______________________________ DOB: ____________
Sex: ❑ Female ❑ Male SS #: ______________________________________
1° Language: _____________ Wt:______ ❑kg ❑lbs Ht:______❑cm ❑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 + Shipping Information

Prescriber Name:____
NPI #: ____
Address: ____
Apt/Suite #________ City:______________ State:_______ Zip:________
Contact: ____
Phone: ______________________ Alternate: _____________________
Fax: ____
Email address____
If shipping to prescriber: ❑ 1st Fill ❑ Always ❑ Never

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

Diagnosis ICD-10:

❑ M80.0 **Age-related** osteoporosis **with** fracture ❑ M80.8 **Other** osteoporosis **with** fracture ❑ M81.0 **Age-related** osteoporosis **without** fracture
❑ M81.6 Localized Osteoporosis ❑ M81.8 **Other** osteoporosis **without** fracture ❑ M85.9 Bone density and structure disorders
❑ M88.0 – M88.9 Paget's Disease ❑ M89.9 Disorder of bone, unspecified ❑ M94.9 Disorder of cartilage, unspecified
❑ Other: ____

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 (provide information below)

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

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. Qty: ❑ 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. Qty: 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. Qty: ❑ 1 PFS (60 mg/1 mL) Refills: ________________
❑ Reclast®	❑ Infuse 5 mg intravenously over no less than 15 minutes once annually. Qty: ❑ 1 Vial (5 mg/100 mL) Refills: ________________

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 Dan's Discount Drug Mart and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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