



## OSTEOPOROSIS ENROLLMENT FORM

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Needs by Date: \_\_\_\_\_

Language: \_\_\_\_\_  Nursing Instruction Required

Ship to:  Patient  MD Office

Prescriber's Name: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

### PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  F  M

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_ Email: \_\_\_\_\_

### PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

#### CLINICAL INFORMATION

(Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis – Please include diagnosis name with ICD-10 code	Additional Information	Therapy: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart
<input type="checkbox"/> ICD-10 _____ Description _____  <b>Disease State Description:</b> <input type="checkbox"/> Postmenopausal osteoporosis with high fracture risk (female) <input type="checkbox"/> Postmenopausal osteoporosis prophylaxis <input type="checkbox"/> Hypogonadal osteoporosis with high fracture risk (male) <input type="checkbox"/> Glucocorticoid-induced osteoporosis treatment / prophylaxis <input type="checkbox"/> Paget's disease <input type="checkbox"/> Other: _____ Date of Diagnosis _____  <b>Test Results:</b> <span style="float: right;"><b>WNL:</b></span> <input type="checkbox"/> Serum calcium _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> SCr / CrCl _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> BMD _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> T score _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight _____ kg/lbs Height _____ cm/in BSA _____ m <sup>2</sup> Allergies _____ Fracture History _____ _____ Prior Failed Therapies: <input type="checkbox"/> Actonel® (risedronate) <input type="checkbox"/> Boniva® (ibandronate) <input type="checkbox"/> Fosamax® (alendronate) <input type="checkbox"/> Prolia® (denosumab) <input type="checkbox"/> Reclast® (Zoledronic Acid Injection) Concomitant Medications _____ _____ Additional Comments _____ _____ Treatment Start Date _____ Treatment End Date _____	

### PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Quantity	Re lls
<input type="checkbox"/> Tymlos®				
<input type="checkbox"/> Boniva® injection				
<input type="checkbox"/> Forteo®				
<input type="checkbox"/> Prolia®				
<input type="checkbox"/> Reclast®				

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT NOTICE:** This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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