Fax Referral To:
814-283-2211
Phone 855-265-8008

Osteoporosis/Osteopenia Enrollment Form

Ship to: ☐ Patient ☐ Office ☐ Other

Date: ____________ Needs by date: ____________

Is patient new to therapy? ☐ YES ☐ NO

Documents necessary for facilitation of referral:

1. **Enrollment form**
2. **Front/Back copies of all insurance/prescription cards**
3. **Copy of most recent labwork and medication profile**

PATIENT INFORMATION	PRESCRIBER INFORMATION
(Complete the following or ***send patient demographic sheet****)*	Prescriber's Name: ____________
Patient Name: ____________	NPI #: ____________
Address: ____________	DEA #: ____________ State License #: ____________
City, State, Zip: ____________	Group or Hospital: ____________
Home Phone: ____________	Address: ____________
Alternate Phone: ____________	City, State Zip: ____________
SS #: ____________	Phone: ____________ Fax: ____________
Date of Birth: ____________ Gender: ____________	Contact Person: ____________ Phone: ____________

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

Please include diagnosis name and ICD-10:

____

____

____

____

Date of primary dx: ____________

Additional Clinical Information:

Weight: ____________ kg/lbs • Height: ____________ in/cm

Allergies: ____________

Failed Therapies: ____________

Dates of previous therapies: ____________

Reason(s) for discontinuation: ____________

Desired start date of therapy: ____________

Injection Training/Home Health Coordination:

Supplies to be sent:

• Injection training/home health will be/has been conducted/coordinated by the Physician's office. ☐ Yes ☐ No • If Yes, Date: _____

• Specialty Pharmacy to coordinate injection training/home health nursing. ☐ Yes ☐ No

Nursing Agency of Choice:

BONE MINERAL DENSITY SCREENING	**Please include dates and results:**
FRACTURE HISTORY	**Please include dates and description of fracture:**

PRESCRIBED THERAPY

☐ **Forteo 600mcg/2.4ml – Inject 20mcg subcutaneously one time daily.**
Dispense #1 pen with _____ refills.
☐ **Mini Pen Needles for Forteo Injection – Use as directed #100**

☐ **Prolia 60mg/1ml prefilled syringe – Inject 60mg subcutaneously every 6 months.**
Dispense #1 syringe with _____ refills.

☐ **Reclast 5mg/100ml – Infuse 5mg (100ml) every 365 days. To be infused under direct supervision of physician.**
Dispense #1 vial with ______ refills.

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said processes.

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right

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PRODUCT SUBSTITUTION PERMITTED (Date)