



# Osteoporosis Enrollment Form

Date: \_\_\_\_\_

Patient Data

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs kg  
 SSN #: XXX-XX-\_\_\_\_ Known Allergies: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Alternate Caregiver Name: \_\_\_\_\_ Phone of Caregiver: \_\_\_\_\_

Ins. Data

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
 Policy: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy: \_\_\_\_\_ Group#: \_\_\_\_\_

Diagnosis

M81.0 Age-related osteoporosis  Other: \_\_\_\_\_  
 M81.8 Other Osteoporosis \_\_\_\_\_

Clinical Information

*To expedite prior authorization, please attach clinical office notes, DEXA Scan report, and any labs completed.*

Lowest DEXA T-score: \_\_\_\_\_ Site: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Fracture history site(s): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Has patient had prior treatment for this diagnosis?  Yes  No

Date(s) of previous therapy and medication: \_\_\_\_\_

Reason(s) for discontinuation: \_\_\_\_\_

Medication

Medication	Directions	Quantity	Refills
<input type="checkbox"/> Boniva 3mg/3ml PFS Kit	Infuse 3mg IV over 15-30 seconds every 3 months	#1 kit	
<input type="checkbox"/> Forteo 600mcg/2.4ml pen <input type="checkbox"/> Mini Pen Needles for Forteo Injection	Inject 20mcg subcutaneously one time daily <i>Use as directed</i>	#1 pen #100	
<input type="checkbox"/> Prolia 60mg/1ml PFS	Inject 60mg subcutaneously every 6 months	#1 syringe	
<input type="checkbox"/> Reclast 5mg/100ml	Infuse 5mg (100ml) IV, over no less than 15 minutes, once every year	#1 vial	
<input type="checkbox"/> Tymlos 3120mcg/1.56ml pen <input type="checkbox"/> Pen Needles for Tymlos Injection	Inject 80mcg subcutaneously one time daily <i>Use as directed</i>	#1 pen #100	

Is patient new to this therapy:  YES  NO | Ship to:  Patient  Office  Other | Need by Date: \_\_\_\_\_

Prescriber Data

Prescribers Name: \_\_\_\_\_ DEA#: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_ Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Key Contact#: \_\_\_\_\_

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 process.

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

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