



Osteoporosis Enrollment Form

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: XXX-XX-_____
 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

- M80.0 Osteoporosis with pathological fracture Other: _____
 M81.0 Age-related osteoporosis _____
 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"/> Evenity™ 105mg/1.17ml PFS	Inject 2 syringes (210mg), one after the other, subcutaneously in separate areas once monthly	#2 syringes	
<input type="checkbox"/> Forteo 600mcg/2.4ml pen <input type="checkbox"/> Mini Pen Needles for Forteo Injection	Inject 20mcg subcutaneously one time daily Use as directed	#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	

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

Prescriber Data

Prescriber 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.

fax referral to: **844-812-6227** | phone: **855-265-8008** | **www.vsprx.com**