

**OSTEOPOROSIS
ENROLLMENT / PRESCRIPTION FORM**

Customer Service Phone 1-800-850-9122

Fax to 1-800-218-3221

PATIENT INFORMATION

Last Name	First Name	MI	ID Number
Home Address	City	State	Zip
Date of Birth / /			
Shipping Address (if different from home address) <input type="checkbox"/> Ship to MD		Home Phone Number	Work Phone Number

INSURANCE INFORMATION (fill out entirely or fax a copy of patient's Insurance card, both sides)

Primary Insurance	Secondary Insurance
Policy Number	Policy Number
Group Number	Group Number

MEDICAL INFORMATION

Diagnosis: Postmenopausal Osteoporosis with high risk of fracture (Female) Hypogonadal Osteoporosis with high risk of fracture (Male)
 Prophylaxis, postmenopausal osteoporosis Treatment/prophylaxis, glucocorticoid-induced osteoporosis Paget's disease

Start Date of therapy: _____ (Forteo not to exceed 2 years of therapy) Initiation of Therapy Continuation of Therapy

Weight: _____ lbs kg Height: _____ in cm Date of Measurement: _____ See Attached

Serum Calcium _____ Bone Mineral Density _____ Creatinine Clearance _____ See Attached

Allergies: _____ NKDA

Current Medications: _____ See Attached

Previous Treatment with Bisphosphonates (Actonel, Fosamax) Calcitonin Estrogen Replacement Other _____ See Attached

Reason for discontinuation: _____ See Attached

PRESCRIPTION INFORMATION

Drug	Directions	Quantity	Refills
<input type="checkbox"/> Forteo 600 mcg/2 mL Pen <input type="checkbox"/> Forteo 750 mcg/3 mL Pen	Inject 20 mcg (0.08 mL) subcutaneously daily.	4-week supply	
<input type="checkbox"/> Reclast 5 mg/100 mL	<input type="checkbox"/> Osteoporosis, prophylaxis- 5 mg IV over no less than 15 minutes every 2 years <input type="checkbox"/> Osteoporosis, treatment- 5 mg IV over no less than 15 minutes once yearly <input type="checkbox"/> Paget's disease- 5 mg IV over no less than 15 minutes (patient should receive 1,500 mg elemental calcium and 800 IU vitamin D daily, particularly during the first two weeks after dosing)		
<input type="checkbox"/> Boniva Injection	Inject 3 mg IV over 15-30 seconds every 3 months (to be administered by a healthcare professional)		
Other medication:			

PRESCRIBER INFORMATION

Prescriber Name	Specialty	Office Contact	Phone Number
Address	City	State	Zip
			Fax Number
Today's Date / /	Date Needed By / /	DEA <input type="checkbox"/> On File	NPI <input type="checkbox"/> On File
I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge.			
Prescriber's Signature			

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist. For refills, please call-in or fax 7 days in advance of next appointment.

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