Osteoporosis Enrollment Form

Phone: (844) 773-6779
Fax: (844) 533-1131
Website: www.InfuCareRx.com

PATIENT INFORMATION

Name:
Address:
City: | State/Zip:
Telephone: | DOB: | M F
Language Preference: | Wt: | Ht:

PRESCRIBER INFORMATION

Prescribing Practitioner: | NPI:
Address:
City: | State/Zip:
Office: | DEA:
Contact: | Phone: | Fax:

PRIMARY INSURANCE INFORMATION

Member Name: | M F | DOB:
Address: | City:
State: | Zip: | Telephone: | Alt. Telephone:
Member ID: | Rx Group #: | BIN#:
PCN#: | Customer Service #: | Please attach a copy of the front and back of the patient's insurance card, if available.*****

PLEASE FAX COPY OF: PRESCRIPTION FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

PRESCRIPTION

New Refill | Ship by: | Ship to: Patient's Home Doctor's Office Other:______________________

Drug	Strength	Directions	Quantity	Refills
Forteo®	600mcg/2.4mL	Inject 20mcg subq daily	1 month supply	
Prolia®	60mg	Inject 60mg subq every 6 months	1 month supply	
Reclast®	5mg/100mL	Infuse 5mg once yearly	1 vial	
Tymlos®	2mg/mL	Inject 80 mcg subq daily	1 month supply	
Other:				

DIAGNOSIS AND CLINICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY**

M81.0 -Age- Related Osteoporosis without current pathological fracture
Other: ____

T-score:_____________
Prior Medication Failed: ____
Length of Treatment:____
Reason for Discontinuation: ____
Forteo® Home Health Training Required

TB/PPD test: Positive Negative Date Read: ________________

Patient Weight: ________ kg lbs Height: _______ cm in
Allergies: ____
Lab Data: ____

Additional Clinical Information:

INJECTION TRAINING:

Patient has received pen and injection training | Physician's office to provide injection training | FOSRX/FAST to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature: | **Date:**