

Date Required: \_\_\_\_\_ Ship To:  Patient  MD Office  Other: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  Male  Female  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_

**INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)**

Primary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
 Prescription Card: \_\_\_\_\_ ID: \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_

**To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:**

**PATIENT DIAGNOSIS/CLINICAL INFORMATION**

M81.0 Age- Related Osteoporosis without current pathological fracture  
 Other: \_\_\_\_\_  
 Prior Medication Failed: \_\_\_\_\_  
 Length of Treatment: \_\_\_\_\_  
 Reason for Discontinuation: \_\_\_\_\_

Weight: \_\_\_\_\_  kg  lbs Height: \_\_\_\_\_  cm  in %BSA: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  NKDA  
 Injection Training/Home Health RN visit is necessary.  Yes  No  
 Site of Care:  Home  MD Office  Other: \_\_\_\_\_  
 TB/PPD test:  Positive  Negative  Date Read: \_\_\_\_\_  
 T-score: \_\_\_\_\_  Forteo® Home Health Training Required

**PRESCRIPTION INFORMATION**

Medication	Dose/Strength	Instructions	Quantity	Refills
Forteo®	<input type="checkbox"/> 600mcg/2.4mL	<input type="checkbox"/> Inject 20mcg SQ daily	<input type="checkbox"/> 1 month supply	
Euflexxa®	<input type="checkbox"/> Single-use prefilled syringes (2mL)	<input type="checkbox"/> Inject 2mL (full syringe contents) intraarticularly in each affected knee weekly for 3 weeks. Use separate syringes for each knee.	<input type="checkbox"/> 1 month supply	
Prolia®	<input type="checkbox"/> 60mg	<input type="checkbox"/> Inject 60mg SQ every 6 months	<input type="checkbox"/> 6 month supply	
Reclast®	<input type="checkbox"/> 5mg/100mL	<input type="checkbox"/> Infuse 5mg once yearly	<input type="checkbox"/> 1 vial	
Synvisc®	<input type="checkbox"/> 16mg/2mL	<input type="checkbox"/> Inject intraarticularly 16 mg (2 mL) to affected knee for 3 weeks	<input type="checkbox"/> 1 month supply	
Synvisc-One®	<input type="checkbox"/> 48mg/6mL	<input type="checkbox"/> Inject intraarticularly 48 mg (6 mL) to affected knee once as a single injection	<input type="checkbox"/> 1 month supply	
Tymlos®	<input type="checkbox"/> 2mg/mL	<input type="checkbox"/> Inject 80 mcg SQ daily	<input type="checkbox"/> 1 month supply	
Other:				

**ADDITIONAL COMMENTS**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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