PROFESSIONAL PHARMACY GROUP
Specialty Pharmacy

OSTEOPOROSIS SPECIALTY PROGRAM

Phone: 844-223-7510
Fax: 844-673-6161

PATIENT INFORMATION:

Name: ______________________ Address: ______________________

City: __________ State: ____ Zip: ______ Phone: __________ Alt. Phone: __________

Email: ______________________ DOB: ______ Gender: _____ Height: _____

Weight: _____ Allergies: ______________________

PRESCRIBER INFORMATION:

Name: ______________________ Address: ______________________

City: __________ State: ____ Zip: ______ Phone: __________ Fax: __________

NPI: __________ DEA: __________ Tax I.D.: __________

Office Contact: __________ Phone with Extension: __________

STATEMENT OF MEDICAL NECESSITY:

Date of Diagnosis: __________ Primary ICD-10: __________ Is patient new to therapy? Yes No

Is patient high risk for Fracture? Yes No History of Osteoporotic Fracture? Yes No BMD/T Score: ______

FRAX Score: ______ Contraindication to bisphosphonate therapy? No Yes: Dysphagia GERD Ulcer

FAILED PRIOR TREATMENTS: ______________________

____

REQUIRED INFORMATION: Please fax copy of ***Prescription and Insurance Cards*** (front and back), as well as ***Clinical Chart Notes and Labs/Test Results***

PRESCRIPTION INFORMATION:

Patient Name: ______________________ Date of Birth: __________

Medication	Strength	Directions	Quantity/Refills
Forteo®	600 mcg/2.4 mL Prefilled Pen	Inject 20 mcg (0.08 mL) subcutaneously once daily.	Qty: ______ Refills: ______
Pen Needles	31 guage 5mm 8mm		Qty: ______ Refills: ______
Prolia®	60mg/ml Prefilled Syringe	Inject 60mg subcutaneously every 6 months	Qty: ______ Refills: ______
Tymlos™	3,120mcg/1.56ml Prefilled Pen	Inject 80 mcg (0.04 mL) subcutaneously once daily	Qty: ______ Refills: ______
Pen Needles	31 guage 5mm 8mm		Qty: ______ Refills: ______

PHYSICIAN SIGNATURE REQUIRED:

SIGNATURE: ______________________ DATE: __________