

**1 PATIENT INFORMATION:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
DOB: \_\_\_\_\_ Gender:  M  F Caregiver: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

**2 PRESCRIBER INFORMATION:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
Tax I.D.: \_\_\_\_\_  
Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**3 STATEMENT OF MEDICAL NECESSITY:**

Date of Diagnosis: \_\_\_\_\_ BMD/T-Score: \_\_\_\_\_ Date: \_\_\_\_\_  
 733.00 Osteoporosis FRAX Score: \_\_\_\_\_ Date: \_\_\_\_\_  
 733.01 Senile Osteoporosis Is patient new to therapy?  Yes  No  
 733.02 Idiopathic Osteoporosis Is patient high risk for fracture?  Yes  No  
 733.03 Disuse Osteoporosis History of osteoporotic fracture?  Yes  No  
 733.09 Other Osteoporosis If Yes, Location of Fracture: \_\_\_\_\_  
 733.10 Pathological Fracture Date of Fracture: \_\_\_\_\_  
 V58.65 Long-Term Use of Steroids Contraindication(s) to bisphosphonate therapy?  No  Yes  
 Other \_\_\_\_\_ If Yes:  Dysphagia  GERD  Ulcer  Other \_\_\_\_\_

Prior Failed Treatments:	Length of Treatment:
<input type="checkbox"/> Actonel®	_____
<input type="checkbox"/> Boniva®	_____
<input type="checkbox"/> Forteo®	_____
<input type="checkbox"/> Fosamax®	_____
<input type="checkbox"/> Prolia®	_____
<input type="checkbox"/> Reclast®	_____
<input type="checkbox"/> Other	_____

**Please Attach All Medical Documentation Including:**

DEXA Scan  Medication History  CMP Panel  Other Information Pertinent to the Case

Labs: Calcium: \_\_\_\_\_ Vitamin D: \_\_\_\_\_ Date: \_\_\_\_\_

**4 PRESCRIPTION INFORMATION:**

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> BONIVA®	<input type="checkbox"/> 3mg/3ml Prefilled Syringe	<input type="checkbox"/> Inject 3mg IV every 3 months	1	
<input type="checkbox"/> FORTEO®	<input type="checkbox"/> 600mcg/2.4ml Pen	<input type="checkbox"/> Inject 20mcg SC once daily	1	
<input type="checkbox"/> PROLIA®	<input type="checkbox"/> 60mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 60mg SC every 6 months	1	
<input type="checkbox"/> PEN NEEDLES	<input type="checkbox"/> 31 Gauge <input type="checkbox"/> 4mm <input type="checkbox"/> 5mm <input type="checkbox"/> 6mm			
<input type="checkbox"/> _____	_____	_____		

**5 INJECTION TRAINING:**  Pharmacist to Provide Training  Patient Trained in MD Office  Manufacturer Nurse Support

**6 PRODUCT DELIVERY:**  Patient's Home  Physician's Office  Pharmacy to Coordinate

**7 INSURANCE INFORMATION:** Please Include Front and Back Copies of Pharmacy and Medical Card

**8 PRESCRIBER SIGNATURE:** I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.