DeliverIt Pharmacy Infusion & Specialty

Ortho Osteoporosis ENROLLMENT FORM

Address: 12144 Dairy Ashford Rd., Suite 100, Sugar Land, TX 77478
www.deliveritpharmacy.com
T: 832.939.8137
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PATIENT INFORMATION

(Complete the following or send patient's demographic sheet)

Last Name ______ First Name ______ Sex ☐M ☐F ______ Date of Birth

Address ______ Home Phone ______ Work/Mobile Phone ______

☐ Demographics attached ☐ Through Medical Benefits ☐ Through Pharmacy Benefits

☐ Please check other benefits if initial claim denied or high copay

Preferred Administration Locations:

☐ Sugar Land 12144 Dairy Ashford Rd. Sugar Land, TX 77478
☐ Clear Lake 600 N Koyabashi Dr. Webster, TX 77598
☐ Other: ______

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD-10 code):

☐ M81.0 Age-related osteoporosis without current pathological fracture
☐ M80.0 Age-related osteoporosis with current pathological fracture
☐ Other: ______

- Is Patient pregnant, nursing, or planning pregnancy? ☐ Yes ☐ No ☐ _ N/A | Allergies: ______

Patient Evaluation:

- Is the patient currently taking a bisphosphonate? ☐ Yes ☐ No
  - If Yes, will current bisphosphonate therapy be discontinued? ☐ Yes ☐ No
- Patient is currently taking Calcium and Vitamin D Supplements ☐ Yes ☐ No
- Does the patient have hypocalcemia? ☐ Yes ☐ No
- Is the patient at the risk of fracture? ☐ Yes ☐ No
- History of fragility fracture ☐ Yes ☐ No

- Calcium Level: ______
- Patient's Weight: ______ Kgs/lbs
- Patient's Height: ______ inches
- Date of Last Infusion ______

Bone Mineral density Results:

- DXA Results (g/cm2): ______ Original T-Score: ______ Date: ______

Prior Failed Medications:

☐ Generic Alendronate ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Other ______
Reason for discontinuation of other therapy(ies) ______
Contraindications (if any) ______

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ EVENITY®	☐ 210mg	☐ Inject 210mg SubQ Once every month ☐ **Pre-Medication:** ☐ Acetaminophen ____mg ☐ Diphenhydramine ____mg ☐ Loratadine 10mg	....	....
☐ BONIVA®	☐ 3mg/3ml	☐ Inject 3mg IV every 3 months.	....	....
☐ TYMLOS®	☐ 3120mcg/1.56ml	☐ Inject 80mcg SubQ once daily.	☐ 30days	....
☐ PEN NEEDLES	☐ 31 gauge ☐ 5mm ☐ 6mm ☐ 8mm	☐ Use with Tymlos® Delivery Device daily.	☐ 1 Device(4-week supply) ☐ 3 Devices (12– week supply)	....
☐ FORTEO®	☐ 600mcg/2.4ml Device	☐ Inject 20mcg (0.08ml) SubQ once daily.	☐ 1 Device(4-week supply) ☐ 3 Devices (12– week supply)	....
☐ PEN NEEDLES	☐ 31 gauge ☐ 5mm ☐ 6mm ☐ 8mm	☐ Use with Forteo® Delivery Device daily.	1 Box (100ct)	....
☐ PROLIA®	☐ 1 single use Prefilled Syringe	☐ Inject 60mg SubQ every 6 months.	....	....
☐ RECLAST®	☐ 5mg	☐ Infuse 5mg IV once a year. **Pre-Medication:** ☐ Acetaminophen _____mg PO ☐ Diphenhydramine ____mg PO/IV ☐ Solu-medrol/Solucortef _______ mg_________mg	☐ 1 Vial	....

Physician Signature: ______ ☐ **DAW (Dispense as Written) Date:** ______ **Office Contact:** ______

Physician Address ______ **Phone:** ______ **Fax:** ______

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