Ortho Osteoporosis ENROLLMENT FORM

DELIVERIT PHARMACY Infusion & Specialty

Address: 12144 Dairy Ashford Rd., Suite 100, Sugar Land, TX 77478
T: 832.939.8137 www.deliveritpharmacy.com F: 832.939.8128

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

_____ Sex □M □F _____
Last Name First Name 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

• Patient's Weight: _____Kgs/lbs
• Patient's Height: _____ inches

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.	……...	……...
□ **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.	□ 1 Vial	……

Physician Signature: _____ □ **DAW (Dispense as Written) Date:** _____ **Office Contact:** _____

Physician Address _____ **Phone:** _____ **Fax:** _____

X By Signing this prescription & using Southside's services, you are authorizing Southside to contact insurance companies for prior authorizations on behalf of your practice.