



VITAL CARE RX

Tailored Therapy, Trusted Care

Osteoporosis Enrollment Form

Phone: (877)229-1724 | Fax: (877)229-1725

PATIENT INFORMATION

(Complete the following or send patient demographic sheet.)
Please fax copy of patient's insurance card including both sides

Name: _____
DOB: _____ Gender: M / F Height: _____ Wt: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last 4 digits SS#: _____ Email: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State Lic. #: _____ NPI: _____
Facility Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Contact: _____
Phone: _____ Email: _____

CLINICAL INFORMATION – STATEMENT OF MEDICAL NECESSITY

Diagnosis: 733.0 Osteoporosis 731.0 Paget's disease of bone 733.9 Osteopenia
 Other: _____ Diagnosis Date: _____
Fracture History: Site- _____ Date- _____ Site- _____ Date- _____
BMD T-Score: _____ Date Tested: _____ Anatomical Site: _____
BMD T-Score: _____ Date Tested: _____ Anatomical Site: _____
Is the patient currently taking an oral bisphosphonate? Yes No Allergies: _____
Will the patient continue on the oral bisphosphonate after starting this therapy? Yes No
Does the patient have esophagitis, dysmotility or another GI condition preventing treatment with oral agent? Yes No
Please specify if so: _____
Please list all failed osteoporosis medications (dosage and dates of therapy): _____
Other medical necessity(ies): _____

PRESCRIPTION INFORMATION

<u>Medication</u>	<u>Directions</u>	<u>Quantity</u>	<u>Refills</u>
<input type="checkbox"/> FORTEO®	Inject 20mcg (0.8) using a 31g pen needle (Please select pen needle size) <input type="checkbox"/> 5 mm <input type="checkbox"/> 6 mm <input type="checkbox"/> 8 mm	28 day supply	
<input type="checkbox"/> IV BONIVA®	Inject 3mg IV over 15 to 30 seconds every 3 months (to be administered by health care professional)		
<input type="checkbox"/> RECLAST®	<input type="checkbox"/> For osteoporosis prophylaxis: 5 mg infusion given once every 2 years intravenously over no less than 15 minutes		0
	<input type="checkbox"/> For osteoporosis treatment: 5 mg infusion once a year given intravenously over no less than 15 minutes		0
	<input type="checkbox"/> For Paget's disease: 5 mg infusion given intravenously over no less than 15 minutes (patients with Paget's disease should receive 1500 mg elemental calcium and 800 IU vitamin D daily, particularly during the 2 weeks after dosing)		0
<input type="checkbox"/> PROLIA®	Inject 60 mg SC every 6 months under supervision of healthcare professional	1 syringe	
<input type="checkbox"/> TYMLOS™	Inject 80mcg SC daily using 31g, 8mm pen needle	30 day supply	
<input type="checkbox"/> OTHER			

Ship Medications To: Physician's Clinic Patient's Home

Injection Training Needed: Yes No

Prescriber Signature _____ Date _____ Brand Name Required? Yes

I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, financial treatment and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of this product to another pharmacy of the patient's choice or in the patient's insurer's provider network.