vitalcare SPECIALTY

VITAL CARE RX
Osteoporosis Enrollment Form

Phone: (877)229-1724 I 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: 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, dismotility or aother 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

Medication	Directions	Quantity	Refills
☐ **EVENITY®**	Inject 210 mg (2 syringes) SC once a month by the healthcare provider for up to 12 monthly doses.	30 day supply	
☐ **FORTEO®**	Inject 20mcg (0.8) using a 31g pen needle (Please select pen needle size) ☐ 5 mm ☐ 6 mm ☐ 8 mm	28 day supply	
☐ **IV BONIVA®**	Inject 3mg IV over 15 to 30 seconds every 3 months (to be administered by health care professional)		
☐ **RECLAST®**	☐ For osteoporosis prophylaxis: 5 mg infusion given once every 2 years intravenously over no less than 15 minutes		0
	☐ For osteoporosis treatment: 5 mg infusion once a year given intravenously over no less than 15 minutes		0
	☐ 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
☐ **PROLIA®**	Inject 60 mg SC every 6 months under supervision of healthcare professional	1 syringe	
☐ **TYMLOS™**	Inject 80mcg SC daily using 31g, 8mm pen needle	30 day supply	
☐ **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.