



# Osteoporosis Enrollment Form

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

Patient Data

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs kg  
 SSN #: XXX-XX-\_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Alternate Caregiver Name: \_\_\_\_\_ Phone of Caregiver: \_\_\_\_\_

Ins. Data

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
 Policy: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy: \_\_\_\_\_ Group#: \_\_\_\_\_

Diagnosis

- M80.0 Osteoporosis with pathological fracture  Other: \_\_\_\_\_  
 M81.0 Age-related osteoporosis \_\_\_\_\_  
 M81.8 Other Osteoporosis

Clinical Information

**To expedite prior authorization, please attach clinical office notes, DEXA Scan report, and any labs completed.**

Lowest DEXA T-score: \_\_\_\_\_ Site: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Fracture history site(s): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Has patient had prior treatment for this diagnosis?  Yes  No  
 Date(s) of previous therapy and medication: \_\_\_\_\_  
 Reason(s) for discontinuation: \_\_\_\_\_

Medication

Medication	Directions	Quantity	Refills
<input type="checkbox"/> Boniva 3mg/3ml PFS Kit	Infuse 3mg IV over 15-30 seconds every 3 months	#1 kit	
<input type="checkbox"/> Evinity™ 105mg/1.17ml PFS	Inject 2 syringes (210mg), one after the other, subcutaneously in separate areas once monthly	#2 syringes	
<input type="checkbox"/> Forteo 600mcg/2.4ml pen <input type="checkbox"/> Mini Pen Needles for Forteo Injection	Inject 20mcg subcutaneously one time daily <i>Use as directed</i>	#1 pen #100	
<input type="checkbox"/> Prolia 60mg/1ml PFS	Inject 60mg subcutaneously every 6 months	#1 syringe	
<input type="checkbox"/> Reclast 5mg/100ml	Infuse 5mg (100ml) IV, over no less than 15 minutes, once every year	#1 vial	
<input type="checkbox"/> Tymlos 3120mcg/1.56ml pen <input type="checkbox"/> 5mm pen needles <input type="checkbox"/> 8mm pen needles	Inject 80mcg subcutaneously one time daily <i>Use as directed</i>	#1 pen #100	

Is patient new to this therapy?  YES  NO | Ship to:  Patient  Office  Other | Need by Date: \_\_\_\_\_

Prescriber Data

Prescriber Name: \_\_\_\_\_ DEA#: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_ Contact: \_\_\_\_\_ Preferred Method:  Phone  Fax  Email  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

My signature below authorizes Restore Rx, Inc. staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.

fax referral to: 901-388-0407 | phone: 877-388-0507 | www.restorerx.com