Osteoporosis Enrollment Form

RESTORE Rx SPECIALTY PHARMACY

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs ☐ kg ☐
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
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
☐ Boniva 3mg/3ml PFS Kit	Infuse 3mg IV over 15-30 seconds every 3 months	#1 kit	
☐ Evenity™ 105mg/1.17ml PFS	Inject 2 syringes (210mg), one after the other, subcutaneously in separate areas once monthly	#2 syringes	
☐ Forteo 600mcg/2.4ml pen ☐ *Mini Pen Needles for Forteo Injection*	Inject 20mcg subcutaneously one time daily *Use as directed*	#1 pen *#100*	
☐ Prolia 60mg/1ml PFS	Inject 60mg subcutaneously every 6 months	#1 syringe	
☐ Reclast 5mg/100ml	Infuse 5mg (100ml) IV, over no less then 15 minutes, once every year	#1 vial	

Is patient new to this therapy: ☐ YES ☐ NO | **Ship to:** ☐ Patient ☐ Office ☐ Other | **Need by Date:** _____

Prescriber Data

Prescriber Name: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#: _____ NPI: _____
Contact: _____ Preferred Method: ☐ Phone ☐ Fax ☐ Email
Phone: _____ Fax: _____
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.