Gigi Specialty Pharmacy

Osteoporosis Enrollment Form

A Dose Of Kindness
With Every Perscription.

Ship to: ☐ Patient ☐ Office ☐ Other: Date: Needs by Date:

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____

Address _____

Address 2 _____

City, State, ZIP _____

Home Phone _____

Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

PRESCRIBER INFORMATION

Prescriber's Name _____

State License # _____ UPIN _____

DEA _____ NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

INSURANCE INFORMATION

Prescription Card: Name of Insurer _____ ID # _____ BIN _____ PCN _____ Group _____

Primary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

Secondary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

MEDICAL INFORMATION

Diagnosis

Please include diagnosis name and ICD-9

☐ ICD-9 _____ Diagnosis _____

Disease State Description:

- ☐ Postmenopausal osteoporosis with high fracture risk (female)
- ☐ Postmenopausal osteoporosis prophylaxis
- ☐ Hypogonadal osteoporosis with high fracture risk (male)
- ☐ Glucocorticoid-induced osteoporosis treatment/prophylaxis
- ☐ Paget's disease
- ☐ Other: _____

Date of Diagnosis _____

Test Results: **WNL:**

- ☐ Serum calcium _____ ☐ Yes ☐ No
- ☐ SCr/CrCl _____ ☐ Yes ☐ No
- ☐ BMD _____ ☐ Yes ☐ No
- ☐ T score _____ ☐ Yes ☐ No

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in BSA _____ m^2

Allergies _____

Fracture History _____

Prior Failed Therapies:

- ☐ Actonel (risedronate)
- ☐ Boniva (ibandronate)
- ☐ Fosamax (alendronate)
- ☐ Prolia (denosumab)
- ☐ Reclast (Zoledronic Acid Injection)

Concomitant Medications _____

Additional Comments _____

Treatment Start Date _____ Treatment End Date _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Boniva injection				
☐ Forteo				
☐ Prolia				
☐ Reclast				
☐ BD Pen Needles				

Prescriber's Signature _____

PRODUCT SUBSTITUTION PERMITTED *DISPENSE AS WRITTEN*