



Osteoporosis Enrollment Form

A Dose Of Kindness
With Every Prescription.

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 _____ m²

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
<input type="checkbox"/> Boniva injection				
<input type="checkbox"/> Forteo				
<input type="checkbox"/> Prolia				
<input type="checkbox"/> Reclast				
<input type="checkbox"/> BD Pen Needles				

Prescriber's Signature _____

PRODUCT SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN

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