

# Osteoporosis



toll-free phone 855.611.3399  
toll-free fax 855.826.2596

Patient information	Prescriber + Shipping Information
Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1 <sup>st</sup> Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____ Insurance Plan: _____ Plan ID # _____ <b>Please fax a copy of front and back of the insurance card(s).</b>	Prescriber Name: _____ NPI #: _____ Address: _____ Apt/Suite # _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address _____ If shipping to prescriber: <input type="checkbox"/> 1st Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

## Clinical Information (Please fax all pertinent clinical and lab information)

**Diagnosis ICD-10:**

M80.0 **Age-related osteoporosis with fracture**   
  M80.8 **Other osteoporosis with fracture**   
  M81.0 **Age-related osteoporosis without fracture**  
 M81.6 Localized Osteoporosis   
  M81.8 **Other osteoporosis without fracture**   
  M85.9 Bone density and structure disorders  
 M88.0 – M88.9 Paget’s Disease   
  M89.9 Disorder of bone, unspecified   
  M94.9 Disorder of cartilage, unspecified  
 Other: \_\_\_\_\_

BMD/T-Score(s): \_\_\_\_\_ Location(s): \_\_\_\_\_ Date: \_\_\_\_\_ New therapy for patient?  Yes  No

Osteoporotic fracture – Date(s): \_\_\_\_\_ Location(s): \_\_\_\_\_  None High risk patient?  Yes  No

Risk factor(s) Information: \_\_\_\_\_ Any prior treatment:  No  Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: \_\_\_\_\_

Concomitant Medications: \_\_\_\_\_

Allergies:  NKDA  Other: \_\_\_\_\_

## Prescription information

<input type="checkbox"/> Boniva®	<input type="checkbox"/> Inject the contents of 1 PFS intravenously every 3 months. To be administered by a healthcare professional. Qty: <input type="checkbox"/> 1 PFS (3 mg/3 mL)	Refills: _____
<input type="checkbox"/> Forteo®	<input type="checkbox"/> Inject 20 mcg SQ once daily. Discard device 28 days after first use. Dispensed with BD Mini™ Pen Needles. Qty: 30 Needles per 1 Pen (600 mcg/2.4 mL) <input type="checkbox"/> 1 Pen with 30 Needles <input type="checkbox"/> 3 Pens with 90 Needles	Refills: _____
<input type="checkbox"/> Prolia®	<input type="checkbox"/> Inject contents of 1 PFS SQ every 6 months. Qty: <input type="checkbox"/> 1 PFS (60 mg/1 mL)	Refills: _____
<input type="checkbox"/> Reclast®	<input type="checkbox"/> Infuse 5 mg intravenously over no less than 15 minutes once annually. Qty: <input type="checkbox"/> 1 Vial (5 mg/100 mL)	Refills: _____
<input type="checkbox"/> Tymlos®	<input type="checkbox"/> Inject 80mcg/40mL SQ once daily Qty: <input type="checkbox"/> 1 Pen, 30 day supply	Refills: _____

Injection Training Provided By:  Physician’s office  Pharmacy  Other: \_\_\_\_\_

Prescription will be filled with generic (if available) unless prescriber writes “DAW” (dispense as written): \_\_\_\_\_

Prescriber’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize Thrifty White Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Thrifty White Specialty Pharmacy.

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