Osteoporosis

Employee Owned Thrifty White PHARMACY Specialty Services
toll-free phone 855.611.3399
toll-free fax 855.826.2596

Patient information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt:_____ ❑kg ❑lbs Ht:_____ ❑cm ❑in
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Phone:_____ Alternate Phone:_____
Caregiver name: _____ Relation: _____
Local Pharmacy: _____ Phone: _____
Insurance Plan: _____ Plan ID # _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name:_____
NPI #: _____
Address: _____
Apt/Suite #_____ City:_____ State:_____ Zip:_____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address_____
If shipping to prescriber:❑ 1st Fill ❑ Always ❑ 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
Osteoportic 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

❑ Boniva®	❑ Inject the contents of 1 PFS intravenously every 3 months. To be administered by a healthcare professional. Qty: ❑ 1 PFS (3 mg/3 mL) Refills: _____
❑ Forteo®	❑ 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) ❑ 1 Pen with 30 Needles ❑ 3 Pens with 90 Needles Refills: _____
❑ Prolia®	❑ Inject contents of 1 PFS SQ every 6 months. Qty: ❑ 1 PFS (60 mg/1 mL) Refills: _____
❑ Reclast®	❑ Infuse 5 mg intravenously over no less than 15 minutes once annually. Qty: ❑ 1 Vial (5 mg/100 mL) Refills: _____
☐ Tymlos®	☐ Inject 80mcg/40mcL SQ once daily Qty: ☐ 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.