

# OSTEOPOROSIS DISEASE ENROLLMENT FORM



## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Social Security No \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sex  M  F Weight \_\_\_\_\_ Height \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Mobile \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## PATIENT INSURANCE INFORMATION

Primary Medical Insurance \_\_\_\_\_ Medical Insurance Phone \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Rx Card (PBM) \_\_\_\_\_ Group No \_\_\_\_\_

Prescription Card Bin # \_\_\_\_\_ PCN # \_\_\_\_\_

## TREATMENT ARRANGEMENTS

•Start Date: \_\_\_\_\_ Ship Meds  Home  Doctor's Office

Teaching by:  Doctor's Office  Other: \_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

**Diagnosis (ICD-10 CODE):**  M81.0 Osteoporosis  M80.0 Osteoporosis with fracture  \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Is patient using prescribed therapy in combination with other biologics for MS?  Yes  No

IS patient pregnant, Nursing, Or Planning pregnancy?  Yes  No  N/A Allergies: \_\_\_\_\_

**Patient Evaluation:**

- Does the patient have any of the following conditions?
  - Unexplained elevations of alkaline phosphatase  Yes  No
  - Open epiphysis (i.e., pediatric or young adult patient)  Yes  No
  - Prior radiation therapy involving the skeleton  Yes  No
  - Bone metastases  Yes  No
  - Metabolic bone disease other than osteoporosis  Yes  No
  - Pre - existing hypercalcemia  Yes  No
- Is the patient currently taking a bisphosphonate?  Yes  No
- Is the patient high risk for fracture  Yes  No
- Allergies: \_\_\_\_\_
- Patient Weight : \_\_\_\_\_ kgs/lbs
- Patient Heights : \_\_\_\_\_ inches

If Yes to previous question, will current bisphosphonate therapy be discontinued upon induction Forteo® or Tymlos®  Yes  No  FRAX # \_\_\_\_\_

• For patients continuing Forteo® therapy, how long have they been taking Forteo® or Tymlos® \_\_\_\_\_ Months

- Does the patient have hypocalcemia?  Yes  No
- Will the patient be supplemented with calcium and vitamin D?  Yes  No

**Bone Mineral Density Result:** DXA Result (g/cm2): \_\_\_\_\_ T-Score: \_\_\_\_\_ Date: \_\_\_\_\_ Site: \_\_\_\_\_

DXA Result (g/cm2): \_\_\_\_\_ T-Score: \_\_\_\_\_ Date: \_\_\_\_\_ Site: \_\_\_\_\_

**Fracture History:** \_\_\_\_\_ Date: \_\_\_\_\_ Site: \_\_\_\_\_

**Prior (Failed) Medications:**

Medication	Strength	Duration of Treatment/Reason for Discontinuation
_____	_____	_____
_____	_____	_____

## PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
<input type="checkbox"/> EVENITY®	<input type="checkbox"/> 210mg	<input type="checkbox"/> Inject 210mg SubQ Once every month.		.....
<input type="checkbox"/> BONIVA®	<input type="checkbox"/> 3mg/3ml	<input type="checkbox"/> Inject 3mg IV every 3 months.		.....
<input type="checkbox"/> TYMLOS®	<input type="checkbox"/> 3120mcg/1.56ml	<input type="checkbox"/> Inject 80mcg SubQ once daily.	30days	
<input type="checkbox"/> PEN NEEDLES	31 gauge <input type="checkbox"/> 5mm <input type="checkbox"/> 6mm <input type="checkbox"/> 8mm	Use with Tymlos® Delivery Device daily.	<input type="checkbox"/> 1 Device(4-week supply) <input type="checkbox"/> 3 Devices (12- week supply)	..... .....
<input type="checkbox"/> FORTEO®	<input type="checkbox"/> 600mcg/2.4ml Device	<input type="checkbox"/> Inject 20mcg (0.08ml) SubQ once daily.	1 Box (100ct)	
<input type="checkbox"/> PEN NEEDLES	31 gauge <input type="checkbox"/> 5mm <input type="checkbox"/> 6mm <input type="checkbox"/> 8mm	Use with Forteo® Delivery Device daily.	<input type="checkbox"/> 1 Device(4-week supply) <input type="checkbox"/> 3 Devices (12- week supply)	..... .....
<input type="checkbox"/> PROLIA®	<input type="checkbox"/> 1 single use Prefilled Syringe	<input type="checkbox"/> Inject 60mg SubQ every 6 months.		.....
<input type="checkbox"/> RECLAST®	<input type="checkbox"/> 5mg	<input type="checkbox"/> Infuse 5mg IV once a year.	<input type="checkbox"/> 1 Vial	.....
<input type="checkbox"/> .....				.....

Physician Signature: **X** \_\_\_\_\_  DAW (Dispense as Written) Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Physician Address: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_

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