meijer specialty pharmacy

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# Osteoporosis

## Prescriber Information

Ship Meds to: Patient's Home ◯ Prescriber's Office ◯

| | | | |
|---|---|---|---|
| Prescriber Name: | | ◯ MD ◯ DO ◯ NP ◯ PA | NPI: |
| Office Contact: | | Practice Name / Collaborating Physician: | |
| Address: | | City: | |
| State: | Zip: | Phone: | Fax: |

## Patient Information | PLEASE SEND COPY OF INSURANCE CARD

| | | | | | | |
|---|---|---|---|---|---|---|
| Patient's Name: | Last 4 Digits of SS#: | DOB: / / | Sex: ◯ M ◯ F | Weight: | Height: | Diabetic: ◯ Y ◯ N |
| Address: | City: | State: | Zip: | Allergies: | | |
| Home Phone: | Work Or Cell: | HIPAA Contact: | Emergency #: | Interpreter Needed? ◯ Y ◯ N | | |

## Insurance Information

| | | | |
|---|---|---|---|
| Primary Insurance: | Policy ID: | Group #: | |
| Policyholder Name: | Policyholder DOB: | BIN: | PCN: |

## Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

**ICD-10/Diagnosis Code:** ◯ Osteoporosis with current pathological fracture (M80.____) ◯ Osteoporosis without current pathological fracture (M81.____) ◯ Age-related osteoporosis (M80.0____)
◯ Paget's Disease (M88) ◯ Other: _____

| | | | | |
|---|---|---|---|---|
| T-Score: | Previous Therapies: | | | |
| History of Fractures: ◯ Y ◯ N | Fracture Code: | Site Fracture Code: | Date of Diagnosis: / / | First Dose: ◯ Y ◯ N |

## Prescription Information

| Medication | Quantity/Dose | Sig | Refills |
|---|---|---|---|
| ◯ **AREDIA**® ◯ Vials | ◯ Number of 30 mg vials: _____ ◯ Number of 60 mg vials: _____ ◯ Number of 90 mg vials: _____ | ◯ Infuse _____mg IV over _____ minutes once every _____ | |
| ◯ **BONIVA**® ◯ PFS (IV use) | ◯ 1 carton (1x3mg/3ml) | ◯ Infuse 3 mg IV every 3 months over a period of 15 to 30 seconds | |
| ◯ **EVENITY**™ ◯ PFS | ◯ 1 carton (2x105mg/1.17ml) | ◯ Inject two syringes (210mg) SQ once monthly | |
| ◯ **FORTEO**® ◯ Pen *Needles Required | ◯ 1 carton (1x600mcg/2.4ml) ◯ 3 cartons (1x600mcg/2.4ml) ◯ Pen needles - _____ Box(es) of 30 | ◯ Inject 20 mcg SQ every day ◯ Use one needle daily with injection | |
| ◯ **PROLIA**® ◯ PFS | ◯ 1 carton (1x60mg/ml) | ◯ Inject 60mg SQ every six months | |
| ◯ **RECLAST**® ◯ Vial | ◯ 1 carton (1x5mg/100ml) | ◯ Infuse 5 mg IV over at least 15 minutes once every _____ year(s) | |
| ◯ **TERIPARATIDE** ◯ Pen *Needles Required | ◯ 1 carton (1x620mcg/2.48mL) ◯ 3 cartons (1x620mcg/2.48mL) ◯ Pen needles - _____ box(es) of 30 | ◯ Inject 20mcg SQ every day ◯ Use one needle daily with injection | |
| ◯ **TYMLOS**™ ◯ Pen *Needles Required | ◯ 1 carton (1x3120mcg/1.56ml) ◯ 3 cartons (1x3120mcg/1.56ml) ◯ Pen needles - _____ box(es) of 30 | ◯ Inject 80 mcg SQ once daily ◯ Use one needle daily with injection | |
| ◯ **ZOMETA**® ◯ Vial | ◯ 1 carton (1x4mg/5ml) | ◯ Infuse 4 mg IV over no less than 15 minutes once every _____ | |
| ◯ Other: | | | |

## Injection Training

◯ Patient received injection training ◯ Prescriber's office to provide injection training ◯ Meijer to coordinate injection training

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

| | |
|---|---|
| Prescriber Signature: Date | Prescriber Signature: Date |
| Substitution Permitted | Dispense as Written |