

<b>Prescriber Information</b>		Ship Meds to:	Patient's Home	Prescriber's Office
Prescriber Name:			<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> PA NPI:	
Office Contact:		Practice Name / Collaborating Physician:		
Address:		City:		
State:	Zip:	Phone:	Fax:	

<b>Patient Information   PLEASE SEND COPY OF INSURANCE CARD</b>						
Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:		City:	State:	Zip:	Allergies:	
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? <input type="radio"/> Y <input type="radio"/> N		

<b>Insurance Information</b>			
Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

<b>Clinical Information   PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES</b>				
ICD-10/Diagnosis Code:	<input type="radio"/> Osteoporosis with current pathological fracture (M80.____) <input type="radio"/> Osteoporosis without current pathological fracture (M81.____) <input type="radio"/> Age-related osteoporosis (M80.0.____) <input type="radio"/> Paget's Disease (M88) <input type="radio"/> Other: _____			
T-Score:	Previous Therapies:			
History of Fractures: <input type="radio"/> Y <input type="radio"/> N	Fracture Code:	Site Fracture Code:	Date of Diagnosis: / /	First Dose: <input type="radio"/> Y <input type="radio"/> N

Medication	Quantity/Dose	Sig	Refills
<input type="radio"/> <b>AREDIA®</b> <input type="radio"/> Vials	<input type="radio"/> Number of 30 mg vials: _____ <input type="radio"/> Number of 60 mg vials: _____ <input type="radio"/> Number of 90 mg vials: _____	<input type="radio"/> Infuse _____mg IV over _____ minutes once every _____	
<input type="radio"/> <b>BONIVA®</b> <input type="radio"/> PFS (IV use)	<input type="radio"/> 1 carton (1x3mg/3ml)	<input type="radio"/> Infuse 3 mg IV every 3 months over a period of 15 to 30 seconds	
<input type="radio"/> <b>EVENITY™</b> <input type="radio"/> PFS	<input type="radio"/> 1 carton (2x105mg/117ml)	<input type="radio"/> Inject two syringes (210mg) SQ once monthly	
<input type="radio"/> <b>FORTEO®</b> <input type="radio"/> Pen <small>*Needles Required</small>	<input type="radio"/> 1 carton (1x600mcg/2.4ml) <input type="radio"/> 3 cartons (1x600mcg/2.4ml) <input type="radio"/> Pen needles - _____ Box(es) of 30	<input type="radio"/> Inject 20 mcg SQ every day <input type="radio"/> Use one needle daily with injection	
<input type="radio"/> <b>PROLIA®</b> <input type="radio"/> PFS	<input type="radio"/> 1 carton (1x60mg/ml)	<input type="radio"/> Inject 60mg SQ every six months	
<input type="radio"/> <b>RECLAST®</b> <input type="radio"/> Vial	<input type="radio"/> 1 carton (1x5mg/100ml)	<input type="radio"/> Infuse 5 mg IV over at least 15 minutes once every _____ year(s)	
<input type="radio"/> <b>TERIPARATIDE</b> <input type="radio"/> Pen <small>*Needles Required</small>	<input type="radio"/> 1 carton (1x620mcg/2.48mL) <input type="radio"/> 3 cartons (1x620mcg/2.48mL) <input type="radio"/> Pen needles - _____ box(es) of 30	<input type="radio"/> Inject 20mcg SQ every day <input type="radio"/> Use one needle daily with injection	
<input type="radio"/> <b>TYMLOS™</b> <input type="radio"/> Pen <small>*Needles Required</small>	<input type="radio"/> 1 carton (1x3120mcg/1.56ml) <input type="radio"/> 3 cartons (1x3120mcg/1.56ml) <input type="radio"/> Pen needles - _____ box(es) of 30	<input type="radio"/> Inject 80 mcg SQ once daily <input type="radio"/> Use one needle daily with injection	
<input type="radio"/> <b>ZOMETA®</b> <input type="radio"/> Vial	<input type="radio"/> 1 carton (1x4mg/5ml)	<input type="radio"/> Infuse 4 mg IV over no less than 15 minutes once every _____	
<input type="radio"/> Other:			

<b>Injection Training</b>		
<input type="radio"/> Patient received injection training	<input type="radio"/> Prescriber's office to provide injection training	<input type="radio"/> 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
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Substitution Permitted

Dispense as Written