meijer specialty pharmacy

P: 800-657-2212 • F: 888-592-7723
www.meijerspecialtypharmacy.com

Osteoporosis

Aredia®, Boniva®, Evenity™, Forteo®, Prolia®, Reclast®, Teriparatide, Zometa®

Prescriber Information

Prescriber Name:	○ MD ○ DO ○ NP ○ PA	NPI:	
Office Contact:	Practice Name / Collaborating MD:		
Address:	City:	State:	Zip:
Phone:	Fax:		

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patients Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ○ M ○ F	Weight:	Height:	Diabetic? ○ Y ○ N
Office Contact:	Practice Name / Collaborating MD:					
Address:	City:	State:	Zip:			
Home Phone:	Work/Cell:	HIPPA Contact:	Emergency #:			
Interpreter Needed? ○ Y ○ N	Allergies: ○ Y ○ N **If Yes, list allergies:**					

Insurance Information

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

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®** ○ **PFS *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	
○ **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

If brand is required, please write "DAW" in the box to the right.