Osteoporosis Enrollment Form

Fax Referral To: 1-718-261-6689
Email Referral To: info@healthycornerpharmacy.com
Phone: 1-855-261-6699

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ Address: _____ City, State, ZIP: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____ DOB: _____ Gender: ☐ Male ☐ Female
Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP: _____
Phone: _____ Fax _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ M81.0 Age related osteoporosis without current pathological fracture ☐ M81.8 Other osteoporosis without current pathological fracture
☐ Other Code: _____ Description _____
For additional ICD-10 information, please visit www.icd10-data.com

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Forteo®	600 mcg/2.4 mL	Inject 20 mcg (0.08 mL) subcutaneously once daily.	Quantity: ☐ 1 device (28-day supply) ☐ 3 devices (84-day supply) Refills:_____
☐ Forteo	31G Pen Needles: ☐ 5 mm ☐ 6 mm ☐ 8 mm	Use with Forteo delivery device as directed.	Quantity: ☐ 28-day supply ☐ 84-day supply Refills:_____
☐ Prolia®	60 mg	Inject 60 mg subcutaneously every 6 months.	Quantity: _____ Refills:_____
☐ Reclast®	5 mg	☐ Infuse 5 mg IV once a year over no less than 15 minutes. ☐ Infuse 5 mg IV once every 2 years over no less than 15 minutes.	Quantity: 1 vial Refills:_____
☐ Tymlos™	3120 mcg/1.56 mL	Inject 80 mcg (0.04 mL) subcutaneously once daily.	Quantity: ☐ 1 device (30-day supply) ☐ 3 devices (90-day supply) Refills:_____
☐ Tymlos	31G Pen Needles: ☐ 5 mm ☐ 6 mm ☐ 8 mm	Use with Tymlos delivery device as directed.	Quantity: ☐ 30-day supply ☐ 90-day supply Refills:_____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)
X_____

DISPENSE AS WRITTEN (Date)
X_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize Healthy Corner Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.