



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

DISPENSE AS WRITTEN

(Date)

X _____ 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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.