OSTEOPOROSIS
Enrollment Form

Deliver Medications To: ☐ Patient's Home ☐ Doctor's Office Date Needed By: _____ Inj. Training/Admin. ☐ Y ☐ N

PATIENT DEMOGRAPHICS

Last Name: First Name: Date of Birth:

Street Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Prescription Insurance: PLEASE ATTACH A COPY OF THE FRONT AND BACK OF THE PATIENT'S CARD

Primary Prescription Insurance: _____ Rx BIN: _____ Rx PCN: _____

Patient ID/Policy Number: _____ Patient Rx Group Number: _____

PATIENT CLINICAL INFORMATION/HISTORY: (PLEASE ATTACH A COPY OF PATIENT'S RECENT CHART NOTES, PATHOLOGY AND LABS)

Diagnosis: _____ ICD-10 Code: _____

Disease State Description:

- ☐ Postmenopausal osteoporosis with fracture risk (female)
- ☐ Postmenopausal osteoporosis prophylaxis
- ☐ Hypogonadal osteoporosis with high fracture risk (male)
- ☐ Glucocorticoid-induced osteoporosis treatment/prophylaxis
- ☐ Paget's disease
- ☐ Other: _____

Date of Diagnosis: _____

Test Results: WNL:

- ☐ Serum calcium _____ ☐ Yes ☐ No
- ☐ Scr/CrCl _____ ☐ Yes ☐ No
- ☐ BMD _____ ☐ Yes ☐ No
- ☐ T score _____ ☐ Yes ☐ No

Weight_____kg/lbs Height_____cm/in BSA_____m2

Allergies: _____

Fracture History: _____

Prior Failed Therapies:

- ☐ Actonel (risedronate)
- ☐ Fosamax (alendronate)
- ☐ Reclast (Zoledronic Acid Injection)
- ☐ Boniva (ibandronate)
- ☐ Prolia (denosumab)

Concomitant Medications: _____

Additional Comments: _____

Treatment Start Date: _____ Treatment End Date: _____

PRESCRIPTION INFORMATION

DRUG	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Boniva injection	3mg PFS	3mg every 3 months administered intravenously over a period of 15 to 30 seconds		
☐ Forteo	600mcg/2.4ml	Inject 20mcg subcutaneous once daily	☐ 1 device (4-week supply) ☐ 3 device (12-week supply)	
☐ NEEDLES 31 gauge ☐ 5mm ☐ 6mm ☐ 8mm		Use with Forteo Delivery Device as directed	☐ 4-week supply ☐ 12-week supply	
☐ Prolia	60mg	Inject 60mg subcutaneous every 6 months		
☐ Reclast	5mg	Infuse 5mg IV once a year	1 vial	
☐ Tymlos	2000mcg/mL	Inject 80mcg subcutaneous once daily	☐ 1 device (4-week supply) ☐ 3 device (12-week supply)	
☐ NEEDLES 31 gauge ☐ 5mm ☐ 6mm ☐ 8mm		Use with Tymlos Delivery Device as directed	☐ 4-week supply ☐ 12-week supply	

PRESCRIBER INFORMATION

Prescriber Name: Facility Group or Hospital:

Street Address: City: State: Zip:

Office Phone: Office Fax: Office Contact:

DEA: NPI: UPIN:

Physician Signature: _____ Date: _____

"By signing I hereby authorize Encompass Rx, LLC and its pharmacists, technicians and other employees and agents to disclose, share and submit patient information to health insurers, HMOs, employer group health plans, governmental health programs, or other payors, for the purpose of satisfying such payor's prior authorization requirements with respect to the medication being prescribed for the treatment of our mutual patient."