

OSTEOPOROSIS

Enrollment
Form

FAX: 1-855-322-2087
PHONE: 1-855-443-9944
NPI: 1417216128

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) Boniva (ibandronate)
Fosamax (alendronate) Prolia (denosumab)
Reclast (Zoledronic Acid Injection)
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."