Osteoporosis Order Form

2506 Lakeland Drive, Suite 201, Jackson, Mississippi 39232
Pharmacy phone: (866) 420-4041 Pharmacy fax: (601) 420-4040
www.transcriptpharmacy.com

Patient Information

Patient name ____________________
Address ____________________
City ____________ State ________ Zip ________
Home phone ____________ Cell ____________
DOB ____________ SSN ____________
Drug allergies ____________ ❍Male ❍Female

Prescriber Information

Prescriber name ____________ Lic# ________
DEA# ____________ Tax ID ____________
Practice name ____________________
Address ____________ Suite ________
City ____________ State ________ Zip ________
Office Phone ____________ Fax ____________

Insurance, Medicare or Medicaid Information

Primary Insurance ____________________
Policy # ____________ Group ____________
Insurance phone ____________________

Secondary Insurance(*If applicable*,) ____________________
Policy # ____________ Group ____________
Insurance phone ____________________

Prescription Drug Coverage: Company ____________________ Phone ____________
RXGRP# ____________ RXBIN# ____________ PCN/ID# (if avail.) ____________

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE , PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

Clinical Information

Diagnosis: ❍733.0 Osteoporosis ❍731.0 Pagets disease of bone ❍Other ____________ ICD-9 ________ Diagnosis Date ____/____/____

Fracture History: ____________________

DXA results (g/cm2): ____________ Date Tested ____/____/____

BMD T-Score: ____________ Date Tested ____/____/____ Anatomical Site ____________

BMD T-Score: ____________ Date Tested ____/____/____ Anatomical Site ____________

Is the patient currently taking an oral bisphosphonate? ❍ Yes ❍ No

Will patient continue the oral bisphosphonate after starting this therapy? ❍ Yes ❍ No

Does patient have esophagitis, dismotility or other GI condition preventing treatment with oral agents? ❍ Yes ❍ No Specify: ____________

Please list all failed osteoporosis medications (dosage and dates of therapy): ____________________

____

Other medical necessity(ies): ____________________

Drug name	Prescription Orders (PLEASE CHECK ONE OR MORE)	Quantity	Refills
❍Forteo®	Inject 20ug (0.08ml) SC QD as directed, using a 31G ❍ 5mm ❍6mm ❍8mm needle (please select)	4-week supply	Refills
❍IV Boniva®	3mg/3ml PFS - 3mg IV over 15 to 30 seconds Q 3 months (*to be administered quarterly by a health care professional)*	Qty	Refills
❍Reclast®	❍**For osteoporosis *prophylaxis***: 5 mg infusion given once every 2 years intravenously over no less than 15 minutes ❍**For osteoporosis *treatment***: 5 mg infusion once a year given intravenously over no less than 15 minutes ❍**For Pagets disease:** 5 mg infusion given intravenously over no less than 15 minutes (patients with Paget's disease should receive 1500 mg elemental calcium and 800 IU vitamin D daily, particularly during the 2 weeks after dosing)	Qty	Refills
Other medication	Directions	Qty	Refills

Deliver to: ❍ Patient's home ❍MD's office ❍ 1st dose to MD's office, remaining refills to patient home (Shipping is via 2-Day Air. Temperature sensitive Rxs are shipped cold)

Would you like our pharmacy to arrange injection training for Forteo? ❍Yes ❍ No

We authorize Transcript Pharmacy, its employees and agents, to assist with delegated prior authorization requests to the fullest extent allowable by law and insurer guidelines.

____________ ____________ ____________ ____________

Prescriber name or signature **Office Contact Name (Nurse, MA, Other)** **Preferred phone number & extension** **Date**