



## 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 \_\_\_\_\_ Secondary Insurance (*If applicable*) \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group \_\_\_\_\_ Policy # \_\_\_\_\_ Group \_\_\_\_\_  
 Insurance phone \_\_\_\_\_ 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, dysmotility 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
<input type="radio"/> Forteo®	Inject 20ug (0.08ml) SC QD as directed, using a 31G <input type="radio"/> 5mm <input type="radio"/> 6mm <input type="radio"/> 8mm needle (please select)	4-week supply	Refills
<input type="radio"/> IV Boniva®	3mg/3ml PFS - 3mg IV over 15 to 30 seconds Q 3 months ( <i>to be administered quarterly by a health care professional</i> )	Qty	Refills
<input type="radio"/> Reclast®	<input type="radio"/> For osteoporosis <i>prophylaxis</i> : 5 mg infusion given once every 2 years intravenously over no less than 15 minutes <input type="radio"/> For osteoporosis <i>treatment</i> : 5 mg infusion once a year given intravenously over no less than 15 minutes <input type="radio"/> 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
<input type="radio"/> Prolia®	Inject 60mg SQ every 6 months under supervision of healthcare professional	1 syringe	Refills
Other medication	Directions	Qty	Refills

Deliver to:  Patient's home  OMD's office  1<sup>st</sup> dose to MD's office, remaining refills to patient home (Shipping is via 2-Day Air. Temperature sensitive Rx's 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