Osteoporosis
Enrollment Form

Phone: 844-309-7171
Fax: 844-309-7173

1. PATIENT INFORMATION

Patient Name	☐ Male ☐ Female	Allergies	
Date of Birth	SSN#		
Address	City	State	Zip
Phone # (Home)	(Work)	Email address	
Caregiver Name	Emergency Contact Phone		

2. INSURANCE INFORMATION

Primary Insurance	Rx Ins: BIN #_________ PCN # _________	Policyholder
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #

3. DIAGNOSIS INFORMATION AND CLINICAL INFORMATION

☐ M81.0 Age related without current fracture	☐ M81.8 Other Osteoporosis
Patient Information: Weight___________lb/kg Height___________in/cm	

4. PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
☐ Forteo®	600 mcg/2.4 mL	Inject 20 mcg (0.08 mL) subcutaneously once daily.	☐ 1 device (28-day supply) ☐ 3 devices (48-day supply)	
☐ 31G Pen Needles ☐ 5 mm ☐ 6 mm ☐ 8 mm		Use with Forteo delivery device as directed.	☐ 28-day supply ☐ 84-day supply	
☐ Prolia® syringe	60 mg	Inject 60 mg subcutaneously every 6 months.	1 syringe	
☐ Tymlos	3120 mcg/1.56 mL	Inject 80 mcg (0.04 mL) subcutaneously once daily.	☐ 1 device (30-day supply) ☐ 3 devices (90-day supply)	
☐ 31G Pen Needles ☐ 5 mm ☐ 6 mm ☐ 8 mm		Use with Tymlos delivery device as directed.	☐ 30-day supply ☐ 90-day supply	

5. DELIVERY INSTRUCTIONS

☐ Physicians Office ☐ Patient's Home	☐ Other	Date Medication Needed
	Address	
	City/State/Zip	

6. PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution
Phone	Fax	E-Mail
Address	City/State/Zip	
License #	DEA #	

Physician's Signature ____ **Date** ______________
(required to process prescription – stamped signatures are not permissible)

Please fax to AllyScripts Specialty Pharmacy at 844-309-7173.
Faxed prescription forms will only be accepted from prescribing practitioners.