Diplomat Specialty Pharmacy

Single Point of Contact for Office
877.575.SPOC (7762)
****FAX: 877.301.8207****

Osteoporosis Enrollment

Patient Information

Date:____________ Patient SS#:____________ ☐ Male ☐ Female
Patient's First Name:____________ Patient's Last Name:____________
Address:____________ City:____________ State:________ Zip:________
Best Phone Number:____________ Alternate Phone Number:____________
DOB:____________ Weight:____________ kgs or lbs (circle one) Recorded Date:____________
Caregiver:____________ Allergies:____________

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Clinical Information

DIAGNOSIS:

- ☐ 733.00 Osteoporosis, Unspecified
- ☐ 733.01 Senile Osteoporosis
- ☐ 733.02 Idiopathic Osteoporosis
- ☐ 733.03 Disuse Osteoporosis
- ☐ 733.09 Other Osteoporosis
- ☐ V58.65 Long-term (current) use of Steroids
- ☐ Other: ____________

Prior (FAILED) Therapy:

Therapy	Date(s)
☐ **Fosamax**	
☐ **Actonel**	
☐ **Forteo**	
☐ **Prolia**	
☐ **Reclast**	
☐ **Boniva**	
☐ **Other (please list):**____________	

Date of Diagnosis:____________ BMD/T-Score:____________ Is patient new to therapy? ☐ Yes ☐ No
History of osteoporotic fracture? ☐ Yes ☐ No
If no, is patient at high risk? ☐ Yes ☐ No
If yes, date of fracture:____________ Location of fracture:____________

Prescription

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ Forteo®	☐ 600 mcg/2.4 mL Pen	☐ Inject 1 dose (20 mcg) subcutaneously once daily. Discard device 28 days after first use.	☐1 pen *(4-week supply)* ☐3 pens *(12-week supply)*	______
☐ BD® Mini Pen Needles	☐ 31G x 3/16"	☐ Use with Forteo® pen once daily as directed	☐ #100 Pen Needles ☐ #30 Pen Needles	______
☐ Prolia®	☐ 60 mg/1 mL PFS	☐ Inject the contents of 1 syringe (60 mg) subcutaneously every 6 months	1 Prefilled Syringe	______
☐ Reclast®	☐ 5 mg/100 mL vial	☐ Infuse 5 mg intravenously over no less than 15 minutes once annually	One: 5 mg/100 mL vial	___0___
☐ Boniva®	☐ 3 mg/3 mL PFS	☐ Inject the contents of 1 syringe (3 mg) intravenously every 3 months. To be administered by a healthcare professional.	One: 3 mg/3 mL PFS	______

Forteo® Injection Training

- ☐ Patient has received pen and injection training
- ☐ Physician's office to provide injection training
- ☐ Diplomat Pharmacy to coordinate injection training

Prescriber Information

Date Shipment Needed:____________ Ship to: ________Patient ________Physician/Clinic
Ship to Other:____________
Physician's Name (please print): ____________ Contact Name: ____________
Phone #: ____________ Fax #: ____________ NPI #: ____________
Office Address: ____________ City: ____________ State: ________ Zip: ________

I authorize Diplomat Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature:____________ Date:____________

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