ENVISIONSPECIALTY

Osteoporosis Enrollment Form
Phone: 877-437-9012 Fax: 877-309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: ______________________________
Date of Birth: _________ Sex: M or F Caregiver: ____________________
Address: ______________________________
City: __________________State: ____________Zip: ______________
Home Phone: __________________ Work Phone: __________________
Cell Phone: _______________ E-mail: ____________________
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: ______________________________
Insurance Company Phone: ______________________________
Policy holder: ______________________________
Policy holder Employer: ______________________________
Relationship to Patient: ______________________________
ID# __________________________Group# ______________________

Prescriber Information

Practice/ Organization Name: ______________________________
Prescriber Name: ______________________________
Address: ______________________________
City: ________________________State: ______________ Zip: __________
Phone#: ________________________Fax#: ________________________
DEA# __________________________NPI# ________________________
License#: __________________Medicaid UPIN#: ____________________
Physician Specialty: ______________________________

Date Shipment Needed: ______________________________
Ship to: ☐ Patient ☐ Prescriber ☐ Other: ____________________
Shipment Address: ___________________________Attn: ______________
City: ______________________State: _______________Zip: ____________

If shipped to the prescriber's office,Prescriber accepts on behalf of patient for administration in office.

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Clinical Information and Prescription

Diagnosis: ☐ M81.0 Age-related osteoporosis w/o fracture ☐ M80.0 Age-related osteoporosis w/ fracture ☐ M81.8 Other osteoporosis w/o fracture ☐ M80.80 Other osteoporosis w/fracture
☐ Other: _ _ . _ _ _ Description: ______________________________
History of fracture: ☐ Yes ☐ No Bone Density T-score: ____________________
Risk Factors Present: ______________________________
Patients Allergies: ______________________________

Latex allergy: ☐ Yes ☐ No
Patient Weight: _________ lbs or kgs Patient Height: _______ cm or in Date: ____/____/______

Medication History

Previous Medications	Duration of Use	Reason for Discontinuation

☐ **Boniva**® (ibandronate) 3mg IV bolus every 3 months
☐ **Forteo**® (teriparatide) Pen 20mcg SC once daily. Dispense with #100 pen needles
Injection training needed? ☐ Yes ☐ No ☐ In-office training scheduled
Anticipated date of first injection: ____/____/_______
☐ **Prolia**® (denosumab) 60mg SC every 6 months
☐ **Reclast**® (zoledronic Acid) 5mg IV once yearly
☐ **Tymlos**® (abaloparatide) Pen 80mcg SC once daily. Dispense with #100 pen needles
Injection training needed? ☐ Yes ☐ No ☐ In-office training scheduled
Anticipated date of first injection: ____/____/_______

Quantity Prescribed: ☐QS 30 days or interval listed above ☐Other: __________
Refills Authorized: ☐ 0 ☐1 ☐2 ☐3 ☐ 6 mos ☐1 yr ☐Other: __________

Date Shipment Needed: ____/____/_______ **Ship to: ☐ Patient ☐ Prescriber ☐ Infusion Clinic**
Shipment Address: ______________________________Attn: ____________________
City: ______________________________State: ______________________Zip: ____________

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

X______________________________ ____/____/____________
Physician Signature (no stamps) **Date**
If physician requests Brand Name only, DAW MUST be HANDWRITTEN in the following space provided: