Ortho Osteoporosis
ENROLLMENT FORM

DELIVERIT™
Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		DOB		Gender	Male ☐ Female ☐	Weight	____lbs ☐ kg ☐
SSN		Phone		Allergies			
Address		City		State		Zip Code	

Patient Insurance Information

(Or Attach Face Sheet from Patient Chart)

Primary Insurance		Name of the Insured		Relationship	
Member ID#		Group #		Insurance Phone #	
Secondary Rx Carrier		Rx ID #		Rx Group #	

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD-10 code):

☐ M81.0 Age-related osteoporosis without current pathological fracture

☐ M80.0 Age-related osteoporosis with current pathological fracture

☐ Other: _____

- Is Patient pregnant, nursing, or planning pregnancy? ☐ Yes ☐ No ☐ N/A | Allergies: _____

PATIENT EVALUATION:

- Is the patient currently taking a bisphosphonate? ☐ Yes ☐ No
  If Yes, will current bisphosphonate therapy be discontinued? ☐ Yes ☐ No
- Calcium Level: _____
- Date of Last Infusion: _____

BONE MINERAL DENSITY RESULTS:

- DXA Results (g/cm2):_____ Original T-Score: _____ Date: _____

Prior Failed Medications:

☐ Generic Alendronate ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Other _____

Reason for discontinuation of other therapy(ies)_____

Contraindications (if any) _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ BONIVA®	☐ 3mg/3m	☐ Inject 3mg IV every 3 months.	.....	.....
☐ TYMLOS®	☐ 3120mcg/1.56ml	☐ Inject 80mcg SubQ once daily.	☐ 30 days	.....

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PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ EVENITY®	☐ 210mg	☐ Inject 210mg SubQ Once every month ☐ Pre-Medication: ☐ Acetaminophen _____mg ☐ Diphenhydramine_____mg ☐ Loratadine 10mg	.....	.....
☐ PEN NEEDLES	☐ 31 gauge ☐ 5mm ☐ 6mm ☐ 8mm	☐ Use with Tymlos® Delivery Device daily.	☐ 1 Device (4-week supply) ☐ 3 Devices (12– week supply)	.....
☐ FORTEO®	☐ 600mcg/2.4ml Device	☐ Inject 20mcg (0.08ml) SubQ once daily.	☐ 1 Device (4-week supply) ☐ 3 Devices (12– week supply)	.....
☐ PEN NEEDLES	☐ 31 gauge ☐ 5mm ☐ 6mm ☐ 8mm	☐ Use with Forteo® Delivery Device daily.	☐ 1 Box (100ct)	.....
☐ PROLIA®	☐ 1 single use Prefilled Syringe	☐ Inject 60mg SubQ every 6 months.	.....	.....
☐ RECLAST®	☐ 5mg	☐ Infuse 5mg IV once a year. ☐ Pre-Medication: ☐ Acetaminophen _____mg PO ☐ Diphenhydramine _____mg PO/IV ☐ Solu-medrol/Solucortef _____ mg _____mg	☐ 1 Vial	.....

Prescriber Insurance Information

Prescriber Name		NPI#		Office #		Fax #	
Address		City		State		Zip Code	

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

☐ DAW (Dispense as written).

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.

Date

Prescriber's Signature

X_____