

OSTEOPOROSIS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 FAX: 800-530-8589 WEB: www.HealthDyneSpecialty.com To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

	Patient: Care							ər:					
NO	DOB:	Male	Female	Weight:	kgs or	lbs (check one)	Height:	in or	cm (check one)	Recorded Date: _			
IATIO	Address:					City:			State:	Zip:			
FORMA	Best Phone #: Cell Alternate Phone #:												
INF	Allergies:									Latex Allergy:	Yes	No	
	ICD-10 Code for requested therapy:					ICD-10 Co	ode(s) for other med	dical cor	nditions:				

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

Prior (FAILED) Therapy:									
Therapy	Date(s)			Therapy	Date(Date(s)			
Fosamax				Prolla					
Actonel				Reclast					
Forteo				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:		Loc	ation of fracture:						

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

	MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
TION INFORMATIC	Forteo® New Start? Y N Date therapy started:	600mcg/2.4mL Pen	Inject 1 dose (20mcg) Sub-Q every day. Discard device 28 days after first use. To be administered by a health care professional.	1 Pen (4-week supply) 3 Pens (12-week supply)	
	Prolia®	60mg/1mL PFS Inject the contents of 1 syringe (60mg) Sub-Q every 6 months.		1 Prefilled Syringe	
	Reclast [®]	5mg/100mL Vial	Infuse 5mg IV over no less than 15 minutes once annually. To be administered by a health care professional.	One: 5mg/100mL Vial	0
L RESORIE	Boniva®	3mg/3mL PFS	Inject the contents of 1 syringe (3mg) IV every 3 months. To be administered by a health care professional.	One: 3mg/3mL PFS	
	Other				

	INJECTIO	ON TRAINING:	OFFICE TO COORDINATE			HEALTHDYNE SPECIALTY TO COORDINATE				
Anticipated	d Start Date: _			Prescri	ber Specialty:					
Ship to:	Patient	Physician	Clinic	Other:						
Fax #:										
Office Add	ress:				City:		_ State:	Zip:		
The terms and conditions posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by										
reference. The data privacy terms posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by										
reference. I understand that HealthDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.										
Use su	ostitution	Dispense as wi	itten							

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MEDICAL ASSESSMENT