OSTEOPOROSIS SPECIALTY CARE PROGRAM

Phone: **888-623-3133** • Fax: **844-673-2245**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____

DOB: _____ Gender: ❍ M ❍ F Caregiver: _____

Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

NPI: _____ DEA: _____

Tax I.D.: _____

Office Contact: _____ Phone: _____

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3 STATEMENT OF MEDICAL NECESSITY:

Date of Diagnosis: _____

ICD-10: _____

Other: _____

Is patient new to therapy? ❑ Yes ❑ No

Is patient high risk for fracture? ❑ Yes ❑ No

History of osteoporotic fracture? ❑ Yes ❑ No

BMD/T-Score: _____ Date: _____ FRAX Score: _____ Date: _____

If Yes, Location of Fracture: _____ Date of Fracture: _____

Contraindication(s) to bisphosphonate therapy? ❑ No ❑ Yes

If Yes: ❑ Dysphagia ❑ GERD ❑ Ulcer ❑ Other _____

Please Attach All Medical Documentation Including:

❑ DEXA Scan ❑ Medication History ❑ CMP Panel ❑ Other Information Pertinent to the Case

Labs: Calcium: _____ Vitamin D: _____ Date: _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Prior Failed Treatments:	Length of Treatment:
❑ Actonel®	
❑ Boniva®	
❑ Forteo®	
❑ Fosamax®	
❑ Prolia®	
❑ Reclast®	
❑ Other	

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ FORTEO®	❑ 600mcg/2.4ml Pen	❑ Inject 20mcg SC once daily	1	
❑ PEN NEEDLES	❑ 31 Gauge ❑ 5mm		100	
❑ PROLIA®	❑ 60mg/ml Prefilled Syringe	❑ Inject 60mg SC every 6 months	1	
❑ TYMLOS™	❑ 3,120mcg/1.56ml Prefilled Pen	❑ Inject 80mcg subcutaneously once daily into the periumbilical region of the abdomen	1	
❑ PEN NEEDLES	❑ 31 Gauge ❑ 8mm		100	
❑ _____	_____	_____		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.