Pharmacy Fax Number: _____

Faxed by: _____

OSTEO HEALTH
Prescription Form

Prescription Authorization

Completed ☐

Today's Date _____ **Physician's Signature** _____ **(must be a wet signature)**

Prescriber Information

Completed ☐

First Name_____ Last Name_____ NPI#_____ DEA#_____ Lic #_____

Practice Name_____ Specialty_____

Address_____ City_____ State_____ ZIP_____

Phone_____ Fax _____ Email _____

Contact Person_____ Title_____ Direct Line_____ Ext_____

Patient Information

Completed ☐

First Name_____ Last Name_____ DOB_____ SSN#_____

☐ Female ☐ Male Height_____in *Weight_____lbs* Pregnant? (Y/N) _____ Alcohol Use? (Y/N) _____ Tobacco Use? (Y/N) _____

Address_____ City_____ State_____ ZIP_____

Cell Phone_____ Home Phone_____ Email_____

Prescription Information

Completed ☐

	Medication	*Strength*	*Sig (Directions for Use)*	*Disp Qty*	*Refills*
☐	**Forteo®** *(teriparatide)*	☐ 600mcg/2.4mL Device	☐ Inject 20mcg (0.08mL) SC once daily ☐ **Other**: _____		
☐	**Prolia®** *(denosumab)*	☐ 60mg Vial	☐ Inject 60mg SC once every SIX months ☐ **Other**: _____		
☐	**Reclast®** *(zoledronic acid)*	☐ 5mg Vial	☐ Infuse 5mg IV once per year as directed ☐ **Other**: _____		
☐	**Tymlos®** *(abaloparatide)*	☐ 3120mcg/1.56mL Pen	☐ Inject 80mcg SC once daily as directed ☐ **Other**: _____		
☐	**Injection Supplies**	☐ 31g x 5mm Needle ☐ 31g x 6mm Needle ☐ 31g x 8mm Needle	☐ Use with **Forteo®** delivery device as directed, 0.08mL SC once daily ☐ Use with **Tymlos®** delivery device as directed, 0.04mL SC once daily ☐ **Other**:_____		
☐	**Other Rx:**				

Diagnosis / Clinical Information *(provide patient clinicals and labs to expedite a Prior Auth)*

ICD-10 Code (Diagnoses) _____ _____ _____ _____ _____ _____

T-Score:_____ **Date of Bone Density Scan:** _____

Step Therapy (Has pt tried & failed previous meds?) If so, which ones & when? _____

_____

Drug Allergies _____

Drug Sensitivities _____

Current Medications _____

Current OTC/Vitamins _____

Recent Hospital Stay or Surgery? (Y/N) _____ If yes, provide details:_____

Insurance Information

Completed ☐

Insurance:_____

ID:_____

BIN:_____

PCN:_____

Group:_____

Secondary? _____