



## Osteoporosis

**Patient Information:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Height/Weight: \_\_\_\_\_  
 Gender: M F Caregiver: \_\_\_\_\_

**Prescriber Information:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
 Tax ID: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**CLINICAL INFORMATION:**

Diagnosis:  M81.0 Osteoporosis - age-related/post-menopausal  M83.5 Osteoporosis - drug-induced  
 M81.80 Osteoporosis - unspecified  Other: (ICD-10): \_\_\_\_\_

T-Score Result: \_\_\_\_\_ Fracture Site: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Contraindications:  GERD  Other: \_\_\_\_\_

Prior Failed Medications:  Alendronate (Fosamax®)  Risedronate (Actonel®)  Ibandronate (Boniva®)  Other: \_\_\_\_\_

**PLEASE FAX COPIES:**  Medical Card (Front and Back)  Prescription Card (Front and Back)  Clinical Notes

Medication	Dosage and Strength	Directions	Quantity	Refills
<input type="checkbox"/> Forteo®	<input type="checkbox"/> 600ug/2.4ml Pen	Inject 20ug (0.08ml) SC once daily. Discard device 28 days after first use.	1	
	<input type="checkbox"/> 31 Gauge 5mm Needles	Use as directed with pen(s).	100	
<input type="checkbox"/> Teriparatide	<input type="checkbox"/> 620ug/2.48ml Pen	Inject 20ug (0.08ml) SC once daily. Discard device 28 days after first use.	1	
	<input type="checkbox"/> 31 Gauge 5mm Needles	Use as directed with pen(s).	100	
<input type="checkbox"/> Prolia®	<input type="checkbox"/> 60mg/ml PFS	Inject 60mg (1ml) SC once every 6 months.	1	
<input type="checkbox"/> Reclast®	<input type="checkbox"/> 5mg/100ml Vial	<input type="checkbox"/> Infuse 5mg (100ml) every year. <input type="checkbox"/> Infuse 5mg (100ml) every 2 years.	1	
<input type="checkbox"/> Evenity®	<input type="checkbox"/> 105mg/1.17 ml PFS	Inject 210mg SC once monthly	1	
<input type="checkbox"/> Other	<input type="checkbox"/> _____	<input type="checkbox"/> _____		

*By signing this form and utilizing our services, you are authorizing FountainRx and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and patient assistance programs. Generic substitution is permissible as provided by law. My signature certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate and the therapy identified is medically necessary.*

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_